Acute Care Hospitals Within the San Gabriel Valley: Criteria Employed when Referring Patients to Non-Medical Home Care Companies

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ABSTRACT

Background: The purpose of this research project was to determine what criteria acute care hospitals within the San Gabriel Valley use when referring senior patients to non-medical home care companies upon discharge. There was much anecdotal evidence suggesting significant gaps in hospitals' understanding of the non-medical home care industry, as well as pitfalls patients may encounter due to the unregulated state of the industry in California. This study was built and conducted using a needs assessment research model, to establish the state of hospital understanding regarding home care and the protocols used to assess home care agencies.

Objectives: The major objective of this research was to serve as a pilot study to determine whether local discharge planning practices and attitudes suffer from the same deficiencies as discovered in the literature review.

Methods: Surveys were provided to ten hospitals within the San Gabriel Valley, with facility size ranging from 49 to 453 patient beds. Data was analyzed using descriptive and correlational tests.

Results: A number of results showing statistical significance. An example of this study's findings shows that while 100% of responding hospitals create and provide patients with lists of homecare companies, none of these respondents screen, and 80% do not provide patients with tools to screen, the companies whose info they provide.

Conclusions: Hospitals were largely unaware that non-medical homecare is not regulated within California, the risks associated with hiring "registries", and that seniors prefer to receive care at home versus in a facility. It was clear from the research that hospitals need education on current realities in the local homecare industry, in order to avoid placing fragile seniors at further risk. Future interventions based on these findings will include: development and replication of the study survey with a larger, diverse sample to increase external validity, provide data driven education to hospital case management departments, and education of the senior population to the specific risks they may encounter when entering a contract with a homecare company.

CHAPTER 1: DESCRIPTION OF THE PROBLEM

Section 1.1: Statement of Purpose

To determine what criteria and/or procedure hospital discharge planners use in selecting a non-medical home care agency to refer discharged patients needing post-hospital assistance.

Section 1.2: Setting of the Problem

Senior citizens often receive non-medical in-home care services, which typically include assistance with activities of daily living, such as: bathing, meal preparation, grooming, errands, companionship, etc. Seniors and their families rely on these services in order to prevent premature institutionalization for any needed care.

Section 1.3: History and Background of the Problem

While seniors and their families often proactively seek out in-home care services, a considerable volume of referrals are available through hospital discharge planners, who are responsible for arranging care for patients after they are discharged from the hospital. The many patients discharged from local area hospitals each day must often must arrange for care at home on short notice, and with little experience dealing with this type of care.

With the population of aging "baby-boomers" needing more medical and non-medical care, scores of new home care agencies have sprouted to meet the increased demand for these services. Hospital case managers and discharge planners receive marketing materials and in-person visits from dozens of competing home care companies, all of whose material promise a high level of performance for very similar or identical services. There is presently no governing body which licenses or validates non-medical in-home care companies in California. This lack of legal oversight allows for a wide variance in the actual performance of various home care agencies, regardless of what

agency provided marketing materials may claim. In fact, many home care agencies engage in business practices that increase risk for their elderly clients, such as: utilizing independent contractors, not conducting criminal background checks on caregivers, not covering caregivers with worker compensation insurance, etc. It appears that hospital discharge planners are largely ignorant when it comes to the practices within the non-medical home care industry. This ignorance is problematic because reputable agencies are put forth on the same plane as disreputable agencies, with families often unaware of how to properly screen or compare agencies they wish to hire.

Due to the large variety of home care companies that continue to emerge and market to hospital care coordination departments, it is critical to identify key attributes most important to the case managers referring patients to various agencies. In addition, establishing hospitals' current referral protocols will provide guidance on how to best provide education about the realities of the California non-medical home care industry. The ripening "baby-boomer" market has led many new agencies to spring up, often without any adherence to best business practices for the industry. This trend continues to grow, further saturating the home care market and potentially diluting the impact of direct education efforts.

Section 1.4: Scope of the Project

This project will focus on establishing the factors, criteria and/or procedures that hospital case managers use in determining what home care agencies they refer to families of discharged patients. Areas of interest include: any screening of agencies done by the hospital, hospitals' understanding of current homecare industry practices, preferred agency attributes/services, etc.

Section 1.5: Importance or Significance of the Project

Determining the criteria used by hospital case managers in referring families to home care agencies will enable homecare industry response, with a push to educate case managers and discharge planners on the facts that relate to homecare in California. Determining the concerns most pressing to case managers will give the researcher valuable data to evaluate, which could lead to shifts in hospital discharge education and different referrals to homecare based on the feedback received. As discharge planners better equip patients to make informed decisions when hiring homecare companies, lack of industry regulation will play less of a role in protecting seniors. Ultimately, the more accurate information and tools provided to seniors, the less risk discharged patients will face.

Section 1.6: Definition of Terms

Agency: The home care company contracted by the client, and who is responsible for assigning caregivers to the client.

Case Manager (aka: Discharge Planner, Social Worker): Hospital employee responsible for coordinate all necessary care for a patient upon their discharge from the hospital, to enable a smooth transition from the hospital to the patient's home or nursing home.

Care Coordination (aka Case Management): The hospital department that employs case managers and discharge planners.

Client: Individual (or family) who is seeking or utilizing home care for themselves or their loved one.

Home Care: Non-Medical Care for an individual (usually elderly) in their own home. Typical services include: bathing, meal preparation, medication reminders, driving to appointments, light housekeeping, companionship, etc.

Independent Contractor: An individual who is assigned to a client, but whose agency does not withhold payroll taxes, pay into unemployment or workers compensation insurance.

Marketing: Action by homecare companies to provide case managers with information about their company, as well as any follow up or relationship building which takes place.

Referral Source: Any entity who passes along information about or recommend a homecare company to a potential client.

Registry: A company that provides caregivers to the home as independent contractors, meaning the family may be responsible for employment duties and taxes.

CHAPTER 2: LITERATURE REVIEW

The literature reviewed identified the distinctive role of non-medical home care, the possible risks assumed by families when utilizing this type of service (especially in California), the role hospital case managers play in referring home care services to patients, and hurdles to proper referral procedures.

1. ROLE OF HOME CARE:

The phrase "home care" can conjure up different images, ranging from caring for the physical structure of one's home, maintaining the living environment within the home, and individuals receiving personal assistance in their home. This review will deal with the third concept of homecare, which McMackin (2006) defined as a "catchall term generally used to describe all the ancillary services provided to persons to allow them to remain at home. These services may include supportive services such as cooking, shopping, housecleaning, bill paying, transportation, and assistance with the everyday activities of living" (p. 93). This term can also include "personal care services such as hands-on help with dressing, walking, eating, getting in and out of a bed or chair, transferring from bed to toilet or bed to walker, and skin and mouth care." (McMackin, 2006, p. 93) Due to the hands on, highly assistive nature of "personal care", caregivers are often required to have specialized training. This training, depending on the state the care is being provided, can be as simple as extra training and supervision by the agency, to requiring caregiver be certified as a Certified Nurse's Aide or Home Health Aide by the state (McMackin, 2006, p. 93).

As an industry, home care primarily caters to senior citizens. This makes sense, as this key demographic is growing as a percentage of our population, with an estimated "1 in 5 Americans projected to be older than age 65 years by the year 2030" (Socol, 2006,

p. 98). The research shows that the growth of the elderly population, combined with overall increased life expectancy, has, understandably, increased the number of dependent elderly who need continuous long term care (Iecovich, 2007, p. 106). It is not just the growing number of seniors over age 65 that is causing an uptick in those needing home care. The Government Accounting Office finds that seniors age 85 and older are the most likely to need long term care, and this group is anticipated to increase 250% in size between the year 2000 and 2040 (Reder, Hedrick, Guiham, & Miller, 2009, p. 22). The growth of the senior population, coupled with longer life spans, means that the number of years a senior requires home care will also increase. There are other reasons, besides age alone, that trigger the need for care at home. Additional demand for in-home care is created by an estimated 7.6 million elderly, for reasons such as: "acute illness, long-term health conditions, permanent disability, or terminal illness" (Socol, 2006, p. 98). Of course, the combination of being elderly and being released from a hospital or nursing home increases the need for in-home care services (McMackin, 2006, p. 95). The circumstances and types of care provided are nothing new, and homecare is not the only option. Traditionally, people have defaulted to moving to an assisted living community or nursing home to live out their final years. And yet, opting for home care is a growing trend among seniors today, for a variety of reasons.

Personal comfort, autonomy, and thriving:

One factor that underscores the significant growth in seniors seeking non-medical home care is their desire to remain in their own home. The preference to receive care at home versus a nursing home during their senior years is incredibly widespread,

approximately 83% among seniors (McMackin, 2006, p. 96). Despite the traditional stereotype that families simply "ship" their loved ones to the nearest nursing home, seniors' informal caregivers (family, friends, neighbors) tend to share the desire for their loved one to remain at home (Reder, Hedrick, Guiham, & Miller, 2009, p. 29). There are undoubtedly scenarios where remaining in the home is not the best medical option. Surprisingly, the desire to remain at home is so strong that although remaining in the home can present difficulties not encountered in an institution, patients opt to stay at home (Reder, Hedrick, Guiham, & Miller, 2009, p. 29). Aside from familiarity with their home setting, personal autonomy is a compelling reason for seniors to receive care at home.

Where seniors can have little choice in their care when relegated to a nursing facility, home care allows seniors, "especially those with chronic or debilitating health conditions choose home care rather than institutional care for their long term care needs" (O'Doherty, 2006, p. 103-104). The desire to remain in a setting where one has been operated with relative autonomy, such as their own home, can be a compelling option for seniors. Because private duty home care is not usually directed by a physician, but rather the client themselves, seniors and their families who choose to have care in the home are typically able to determine the type, frequency, and duration of care, based on his or her needs (McMackin, 2006, p. 96). In fact, arranging care in the home can now be extended past medical professionals to include: seniors themselves, adult children of parents who are aging and/or frail or demented, trust officers, Certified Public Accountants (CPAs), hospice nurses or volunteers, long-term-care insurance agents, and geriatric care managers (Orsini, 2006, p. 116). This variety of sources allows for better rounded

decision making, creating a scenario where the senior can retain autonomy. Whereas a facility may confine a senior to a specific type of care, receiving care in the home can provide a setting where seniors not only have basic needs met, but can thrive.

An ideal outcome for a senior receiving care in any setting is to achieve the greatest amount of health and happiness possible, given their particular set of circumstances. Homecare can provide a comfortable and familiar setting, while increasing the flexibility of care and therefore improves the possibility of choosing the most appropriate care arrangement for each person (Eija & Marja-Leena, 2005, p. 288). Inherent to homecare is having a caregiver dedicated to the wellbeing of the one senior, which affords greater interaction and enrichment. This best case scenario does not happen by accident, and requires a good plan of care and a reputable agency that employs their staff and carefully matches caregiver and client, in order to provide a long-term solution to a person's desire to age in place (McMackin, 2006, p. 96). The level of coordination and diligence on the part of the homecare agency is critical. It is only through a high level of responsiveness to the specific needs of the senior that homecare can provide clients with comfort, companionship, and the support they need to live a high-quality life at home (McMackin, 2006, p. 96). With proper oversight and attention, the home can be an environment where a senior can not only receive basic care, but thrive.

Homecare exists as an invaluable option for seniors needing help with non-medical activities of daily living. The option to receive care in the home enables seniors to live out their elder years in a comfortable, familiar setting. Home care allows seniors to exercise greater control over their care, to participate more fully, and with more autonomy in the process. In turn, receiving care in the home creates an environment

where a senior can thrive, living as full and normal a life as possible. In spite of the extensive benefits found in receiving care in the home, this avenue of care is not without risks.

2. RISKS OF HOME CARE:

The idea of a stranger entering one's home with unfettered and unsupervised access to a frail senior can be disconcerting. Even more frightening is that families may make care decisions quickly, without considering the risks that can be present in home care. Standards for homecare agencies vary from state to state, and these variances place more responsibility on the family to adequately assess any risks they may encounter. Some of the major risks faced by families seeking homecare (particularly in states such as California) are: the fact that two similar looking but functionally distinct types of homecare service exist, poor education allows families to have unqualified/unwanted caregivers assigned to the home, families becoming financially and legally liable for "accidentally" employing a caregiver.

While there are many types of services available to consumers in the home, non-medical home care is unique in that it is not currently a licensed service within the state of California. Whereas nursing homes are regulated by the State, homecare is largely unregulated and has not got the same safeguards in place to protect caregivers and those who utilize their services (Socol, 2006, p. 99). As a result, quality can vary widely from company to company (Socol, 2006, p. 99). Because of this lack of oversight, consumers must currently choose between two main types of business-based homecare service: agency model, and registry model (McMackin, 2006, p. 94). The agency model typically provides a higher level of screening, supervision and training of caregivers being

assigned into the home (McMackin, 2006, p. 94). This model represents a typical employer-employee relationship, where the employer exerts control over the duties and services provided by their employee. The second type of service, a registry, aims to provide lower upfront cost, while transferring certain employer duties and financial/legal risks onto the client. The concern with this registry type model is that it is easy for a family to be misled into thinking they are simply paying a lower price for equivalent services, but neglect to consider the potential liabilities and additional financial responsibilities that go along with hiring a caregiver through a registry (Socol, 2006, p. 100). On the surface, these two types of service appear identical (if even disclosed to the consumer), yet they can bring vastly different long-term outcomes for families that choose one option over the other. The fact that families are often unaware of the differences between the two models, and because arms-length homecare companies (registries) are relatively easy to operate with little expertise, consumers need to understand the differences and what those differences mean for them in terms of the quality of their care and the responsibilities that they may unknowingly take when they hire an in-home caregiver (Socol, 2006, p. 98). Because of the lack of education in this largely unregulated field, families have few tools to differentiate quality agencies from unscrupulous ones.

Families who opt to bring a caregiver into their home to care for a loved one are placing a great deal of trust in the agency they choose to work with. Because of the vulnerability typical in the frail senior population, it is easy to see how "unmonitored, unsupervised care poses undue risks to the patient, including potential financial risks and the greater possibility of emotional or physical abuse" (Socol, 2006, p. 100). In addition

to the risk of personal abuse, caregivers are in a position to take advantage of the power differential they have with respect to their client. Caregivers without regular supervision or monitoring "can assert undue influence over the client. Stories of clients giving houses and cars, changing wills, and so on to give to caregivers are not unusual" (McMackin, 2006, p. 96). In spite of the serious inherent risks, families often assume that an agency has extensively trained, screened, and monitored the assigned caregiver. As the senior population expands and the demand for homecare services rises, caregivers are in high demand, "making it, unfortunately, relatively easy to get a job as a home care worker in agencies that do not carefully screen applicants and check backgrounds" (Socol, 2006, p. 98). Sometimes families to contract with a registry due to its lower initial affordability, without considering whether the registry provided even basic services such as a criminal background check or ongoing supervision of the assigned caregiver (O'Doherty, 2006, p. 105). Being able to identify these risks requires education and information, while "the largely unregulated, non-government-funded, in-home care industry does not always make it possible for consumers who choose in-home care to understand the issues that determine quality" (Socol, 2006, p. 98). Clients can experience trouble with dishonest caregivers, but a more widespread concern is families becoming financially and legally liable for their caregivers by being considered the employer of the caregiver.

When faced with the decision to use a registry or an agency model (if the choice is even clear at all), a family may not realize substantial risk to their own assets based on the decision they make for care. Using an agency model protects a client because the agency assumes full responsibility for all employment duties such as Worker's Compensation insurance and payroll taxes (Socol, 2006, p. 100). A registry, on the other

hand, simply places or refers a caregiver to a family as an "independent contractor". Depending on how the caregiver is utilized and paid, "determination may be made that an employee-employer relationship is established between the worker and the client" (McMackin, 2006, p. 94). In other words, under this registry independent contractor scenario, the consumer becomes liable for items such as workers compensation, unemployment taxes, and social security (Socol, 2006, p. 99). In the hurry to find adequate care for a loved one, families cannot often distinguish between the two models, and may not know what to ask to better understand the risks they take on in choosing to work with a registry. Consumers who knowingly or inadvertently opt to work with a registry can be surprised with a greater legal liability than they expect because for many purposes (such as tax liability, wage and hour and workers' compensation) they qualify as employers (Milligan, 2006, p. 109). Registries will claim that the caregiver is an "independent contractor", and does not subject the family to any liability. In reality, regardless of using the term "independent contractor", there is gray area when it comes to who is the actual employer of the caregiver (McMackin, 2006, p. 94). A primary factor used to determine whether or not a caregiver is actually an employee of the family, is "whether the borrowing employer had the right to direct and control the manner in which the employee performed the work", which is called the "right to control" (Milligan, 2006, p. 109). The reason a family's status as an employer matters is that employment responsibilities such as supervision, monitoring, government-mandated taxes, and Workers' Compensation coverage fall on the consumer (Socol, 2006, p. 100). The problem of a family being legally considered the employer arises when there is an incident in the course of the caregiver's duties. The potential for caregiver injury in the

home is very high, and Wipfli, Olson, Wright, Garrigues, & Lees, (2012) reported that the lost time injury rate for HCWs (Home Care Workers) is nearly four times higher than the average for all occupations (424 vs. 117 per 10,000 full-time workers) (p. 388). They cited a main reason for injury as stemming from the fact that single caregivers in the home "often perform dangerous manual client transfers without coworker or mechanical assistance" (Wipfli et al., 2012, p. 388). Families receiving care from an "independent contractor" can be caught off guard legally and financially if the caregiver experiences an injury or files for unemployment. In fact, McMackin (2006) pointed out that when a caregiver is injured or becomes unemployed, the client is deemed the "responsible party because it has been determined that the elements of an independent contractor agreement were not met and the relationship is viewed as employee-employer" (p. 94). The reality of being considered the "employer of record" presents significant legal and financial liability for families, who are often unaware that this danger exists. In contrast to the risks inherent to the registry model, when using the agency model, the caregiver is fully employed by the agency, and legal liabilities fall squarely on the agency.

Families who seek a caregiver in the home are tasked with navigating the risks that can be present when using the services of a caregiver. Consumers will need to understand and be able to differentiate between the two models of homecare: an "agency" that fully employs their care giving staff, and a "registry" that passes legal and financial burden on to the family. Families should also be aware of the fact that the lack of licensing in many states creates an environment where abuse and exploitation at the hands of a caregiver may happen. Finally, consumers must seek to understand the legal and financial risks found in hiring a caregiver presented by a registry as an "independent

contractor". While there are thousands of examples of terrific experiences between caregivers and the families they serve, there are risks to receiving care in the home, especially in states that provide no State licensure or oversight.

3. HOSPITAL CASE MANAGER'S ROLE:

Hospital Case Managers, sometimes called "Discharge Planner" or "Social Worker", are the hospital employee responsible for coordinating all necessary care for a patient upon their discharge from the hospital, to enable a smooth transition from the hospital to the patient's home or nursing home. This employee plays a large part in assuring the long term health and recovery of a patient who has been discharged. A number of the case manager's roles overlap, with responsibilities to the patient, as well as to others involved in the patient's care, such as family members or home care entities. Some of the roles a case manager embodies include basic duties such as providing discharge education, forming a proper discharge plan, and arranging most fitting post-discharge for the patient. Another major role for a case manager is effectively communicating the discharge plan to patients and their families, leading to positive results. A third role case managers play is as an advocate for their patients, embodying the ethical responsibility that comes with caring for a sick individual.

Considered the last nursing care contact at a hospital, a case manager's main discharge planning responsibilities were reported by Eija & Marja-Leena (2005) as falling into four areas: patient assessment; development of a discharge plan; provision of services (including patient/family education and services referrals); and follow-up/evaluation (p. 288). Because patients and their families are often overwhelmed with the prospect of arranging for care after discharge, the case manager's input is crucial in

making this transition as smooth as possible. In fact, as Nosbusch, Weiss, & Bobay (2011) reported, proper discharge planning has been linked to patient outcomes at discharge and post hospitalization (p. 772) One trait of successful discharge planning is when care providers and arranged care is based on the individual care needs of the patient and not rigid reimbursement that details the care allowed based on definition of an illness (McMackin, 2006, p. 93). A case manager draws from a variety of available resources to create a discharge plan best suited to the individual patient. This coordination will often include: a proper assessment of the patient's functional status (e.g. ability to move around, carry and pick up things), cognitive potentials and treatment of illnesses, and an adequate co-operation between home care and the discharging hospital, and between home-help services and home nursing (Eija & Marja-Leena, 2005, p.293). A case manager cannot simply use a universal approach to care, and the Journal of Hospital Case Management (2009) pointed out that if there are not additional care resources in place, that a patient should not even be referred care services in the home (p. 28). A case manager is a conduit for valuable communication, not only for an unprepared family (Orsini, 2006, p. 117), but especially important for cooperation between hospital staff and home care personnel at the hospital (Eija & Marja-Leena, 2005, p.292). The case manager usually creates and delivers a care plan to all those involved with homecare, which compiles and accounts for the varying health and mental status of the patient, and when provided to the homecare entity in a timely fashion, increases the likelihood of a successful discharge (Eija & Marja-Leena, 2005, p.292). Patient education is another basic function and role of a hospital case manager. When developing a post-discharge care plan for patients who will need help at home, Case Management Advisor (2010)

instructed case managers to: make sure the patient and family understand what is required of them and that they are aware of all their options, including paying for private home care services (p. 54). Case Management Advisor (2010) highlighted how post discharge services may be especially helpful for those patients whose friends or family who cannot act as their caregiver available, and how case managers should be sure to offer private duty home care services to all patients who could benefit from the services (p. 54). Because much of a patient's recovery depends on how well they can take care of themselves post-discharge, effective communication of self-care information is essential between a case manager and a patient and their families.

The way a case manager communicates information is a critical part of their role in a patient's discharge from the hospital. A case manager must effectively communicate a patient's current health status to the patient and family, as well as to any homecare entities that will be providing care to the patient after discharge. Eija & Marja-Leena (2005) found that good communication between the discharging hospital and homecare is associated with a successful discharge. Eija & Marja-Leena (2005) also reported that successful discharge is impacted by sufficient information on a patient's: "functional ability, cognitive potentials, living environment, economic situation, illnesses and their treatment, and the services the client had previously used and would need in the future" (p. 292). Paying attention to these factors is important to a successful discharge, and studies have conversely shown that a lack of emphasis on these factors is the basis for shortcomings between the discharging hospital and home (Eija & Marja-Leena, 2005, p.292). While effective communication between hospital and home care is essential, properly instructing a patient in self-care after discharge is critical. One study cited by

Nosbusch, Weiss, & Bobay (2011) suggested this be done by nurses consistently assessing a patient's ability to "teach back" self-care instructions (p. 771). Another study they cite suggests that staff nurses should cultivate finely honed communication skills and use them in the delivery of discharge-related information, and that these skills were strongly and positively associated with patients' perception of readiness to return home (Nosbusch et al, 2011, p. 771). Some issues that hamper effective communication between a case manager and elderly patients is that the senior's ability to hear or remember instructions may have deteriorated or they may not recognize their reduced coping capacity for daily living or in dealing with their illness (Eija & Marja-Leena, 2005, p. 292-293). Nosbusch et al (2011) reported that a patient's perception of readiness to go home is significantly predicted by the quality of staff nurses' communication skills during patient encounters addressing discharge learning needs (p.768). They also find that patients and family members view nurses as sources of information and support. (Nosbusch et al, 2011, p.768). Because case managers' work influences a discharged patient's well-being, there are ethical implications to the services they provide.

One component of effectively communicating post-discharge care plans to a patient and their family is the impact the quality of these recommendations will make on a patient's well being. A case manager has an ethical and professional responsibility to make sure a patient has all relevant information pertaining to post-discharge care choices. Case Management Advisor (2010) referenced the standards of care set out by the Case Management Society of America and how "case managers have an obligation to make sure that patients understand all of the options available to them, including the option to pay for private duty home care services" (p.54). They pointed out that ethical principles

require case managers to provide information to patients so they can make informed choices (Case Management Advisor, 2010, p. 54). Just as the journal of Hospital Case Management (2009) warned that incorrectly referring homecare for an unsuitable patient violates ethical standards of justice and patients' entitlement to appropriate care (p.27), Case Management Advisor (2010) pointed out that it is wrong for a case manager to be reluctant in offering homecare services to patients and their families because of the cost. Case Management Advisor (2010) went on to explain how "offering private duty in home care services is consistent with legal and ethical requirements that govern the practice of case management," (p. 54). Because of the many varieties and vast amounts of information related to post-discharge care options, Case Management Advisor (2010) explained that case managers have an ethical duty to serve as an advocate for their patients (p.54). With respect to home care, advocacy can means basic things such as being able to understand and communicate the differences between registries and agencies (Case Management Advisor, 2010, p. 99), along with providing screening questions families can ask to determine the quality of an agency. Some of the questions Socol (2006) suggested include asking how the agency screens and selects caregivers, what types of background checks are conducted, and whether or not the agency assigns independent contractors as caregivers (p. 101). Given how few resources a patient has post-discharge when compared to being admitted to a hospital, it is clear that case managers have a grave responsibility to ensure a patient is as well equipped as possible before discharge from a hospital.

The role a case manager plays in the post-discharge recovery of a patient is fundamental. Coordinating the different care resources, while educating a patient in self-

care, may mean the difference between successful discharge and quick readmission. The ability to employ excellent communications skills when communicating discharge information to a patient will equip the patient to accurately follow post-discharge care instructions. A case manager who understands their role as an advocate for the patient will make sure the patient fully understands the options available to them and guides them in making a decision that will support the care goals. Case managers have a weighty responsibility to the patients they serve, and are critical to the well being of a post-discharge patient.

4. HURDLES TO PROPER REFERRALS:

Literature has shown the roles home care services play in the options for care seniors can utilize. Research points to the risks families face when selecting homecare as a care option, especially in states that do not require licensing, such as California. The literature also makes clear the importance of proper case management and discharge planning in providing the best possible outcome for a post-discharge patient. Nosbusch, Weiss, & Bobay (2011) found that "barriers to efficient and comprehensive discharge planning can lead to ineffective outcomes for patients and family members at discharge and beyond" (p.771). These barriers are shown to include: a lack of communication, standards or process when arranging for discharge; rushed discharges that lead to inadequate patient education and poor coordination of services; and referrers' ignorance of pitfalls and care options pertaining to post-discharge services.

Despite having the clear ethical and professional responsibility to provide effective discharge planning; in practice, Nosbusch et al (2011) found that the system itself suffers from fragmentation and lacking poor interdisciplinary communication (p.

768). Communication among healthcare personnel is key, and Eija & Marja-Leena (2005) determined that health and social care personnel's close co-operation enables the elderly person to maintain their physical, mental and social function after hospital care and prevent re-admissions and premature deaths (p.289). Communication breakdown extends to how a hospital communicates with a homecare company, sometimes only faxing over info on the patient, but the journal of Healthcare Benchmarks & Quality Improvement (2009) said that what is on paper does not replace the need to see the patient in person (p. 35). In fact, HB&QI (2009) found it becoming increasingly rare for hospitals and home care agencies to communicate well during a patient's transition in care, often so busy they only ask if the homecare agency has room for patient (p.35). Some poor communication can be rectified through timely and comprehensive completion of standardized referral forms and creation of formal feedback systems (Nosbusch, Weiss, & Bobay, 2011, p.770). The presence of poor communication points to systemic issues, which Nosbusch et al (2011) said includes: lack of effective systems, structures, standardized processes or reliable assessment tools (p.768). Rather than following protocols, discharge planning was perceived by respondents as random and dependent on the assessment of the individual unit nurse (Nosbusch et al, 2011, p.770). Nosbusch et al (2011) further identified the lack of systematized discharge planning protocols as including: absent or ineffective verbal and written communication, lack of integrated systems and structures, insufficient time, lack of continuity in patient care responsibilities, knowledge that quickly needs updating and role confusion (p.771). Part of the lacking infrastructure is identified by Nosbusch et al (2011) as the lack of feedback hospital nurses receive on patient outcomes associated with their discharge planning

efforts (p.768). The lack of systems and protocols pertaining to discharge planning may play a role in the poor bedside discharge procedures sometimes found in hospitals.

The importance of patient education and providing adequate information is understood as a fundamental part of discharge planning. In spite of this, Golden, Martin, da Silva, & Roos (2011) found that among vulnerable seniors with a recent hospitalization, inadequate information and training at discharge was a concern for both patients and caregivers (p. 57). Golden et al went on to cite that hospitals are to accomplish the rapid transfer of older adults to decrease length of hospital stays, and that this rapidly discharging elderly patients is often done before a safe discharge can be arranged (p. 56). Healthcare Benchmarks & Quality Improvement (2009) pointed out that time constraints placed on discharge planners causes the amount of time preparing for discharges to decrease (p. 34). Nosbusch et al (2011) cited multiple studies that all find lack of time among staff nurses as a barrier to effective discharge planning (p. 769). Education of patients and families is hampered by administrative pressures that promote rapid discharges from hospitals (Golden, Martin, da Silva, & Roos, 2011, p. 58). This is especially troubling because as HB&QI (2009) reported, families are often completely overwhelmed (p. 35). They go on to say that because of this, if the discharge planner does not take time to work with the family, all of the things listed on the discharge planning sheet do not have a chance of being followed" (HB&QI, 2009, p. 35). In another indication of possibly improper discharge planning, the journal of Hospital Case Management (2009) cited a study that showed patients who are discharged from the hospital to home care on Fridays are significantly more likely to be rehospitalized within a week than patients discharged on other days of the week, although the reasons for the

disparity are not clear (p.28). The literature appears to point to a difference between understood discharge planning goals and their actual implementation. It seems part of this discrepancy appears because of ignorance about the options available to patients and their families.

Proper discharge planning includes case managers fully and clearly understanding the post-discharge care options available to families. The literature makes clear that this is not always the case, with a present amount of ignorance on the part of those who provide post-discharge resources to patients and families. An example of this ignorance is that in spite of the legal and financial risks to families who hire registry caregivers, Smith (2006) found that "many professionals in the care continuum did not realize the jeopardy into which they placed clients with inappropriate referrals to nurse registries and private hires" (p. 106). Orsini (2006) suggested that an updated, current list of current homecare agencies is a necessity, as a tool for case managers (p.117). The need for accurate, current resources is substantiated by Nosbusch et al (2011), who found that developing and maintaining adequate knowledge of community resources and services was a challenge for acute care staff nurses (p.769). In spite of case manager being understood as the source for post-discharge discharge planning, Reder, Hedrick, Guiham, & Miller, Barriers (2009) found that physicians influence other professionals involved in the LTC decision such as social and usually have the dominant voice on interdisciplinary teams (p.22). They also found that although the physician is the single key person initiating long term care services, physicians are often not well informed about options (Reder et al, 2009, p. 22). One area Reder et al (2009) cited where physician ignorance is problematic is for patients who may be a good for fit home care services, because "compared to

nurses and social workers, physicians (e.g., geriatricians and primary care physicians) favored rehabilitation and skilled nursing facility care and were less enthusiastic about HCBS (e.g., assisted living, homemaking, and informal care)" (p.23). This can be challenging because physicians lack of familiarity with home care services, and because of this may limit referrals to home care (Reder et al, 2009, p.30) and instead, reflexively refer patients needing long term care to nursing homes. It appears that barriers to proper discharge may also be due to informal referrers such as physicians being ignorant as to the types of non-institutional care available to patients.

CHAPTER 3: RESEARCH STRATEGY AND DATA COLLECTION PLAN

Summary of Chapters 1 and 2

The purpose of this research is to highlight problems found in the hospital discharge planning homecare referral process, and to provide context for the current state of the non-medical homecare industry in Southern California. As identified and explored within the literature review, non-medical home care is not currently licensed or regulated within California, there are wide variances in quality of service that aren't immediately clear to consumers who seek such services. There is perceived ignorance about the non-regulated nature of the industry, even trusted sources of information such as hospital case managers and social workers may unknowingly provide vulnerable seniors with referrals that may prove to be risky.

The literature pointed to four main areas. The first area described the role of non-medical homecare in the spectrum of care available to seniors needing assistance. Literature showed that senior population prefers to receive care at home, and that they utilize services such as cooking, transportation, bathing, walking, etc. The literature then showed that due to the unregulated state of the industry in California, families would unwittingly enter into risky legal and financial scenarios with caregivers hired into the home. One area of particular concern was homecare "registries" that pose as standard employee-based agencies, but shift legal and financial risk of employment requirements onto the family by sending independent contractors. The literature then spelled out the role of case-managers at hospitals and their important role with educating patients and their families with post-discharge instructions. Effectively communicating and referring resources for all appropriate post-discharge care options in an understandable way are central to a case manager's responsibilities. The literature review then revealed ample

literature that highlighted barriers to proper referrals to care. Some of these hurdles include a lack of communication, standards or process when arranging for discharge; rushed discharges that lead to inadequate patient education and poor coordination of services; and referrers' ignorance of pitfalls and care options pertaining to post-discharge services.

3.1.1 Statement of Objectives

The major objective of this research was to serve as a pilot study to determine whether the study should be expanded to include a wider sample of respondents. The literature suggests there are areas presently lacking within the discharge planning setting. The purpose of a wider study would be to identify if these problems are present among the hospitals located within the San Gabriel Valley. Data collected will guide educational campaigns geared toward hospital discharge planners, particularly in areas currently falling short of basic quality expected of discharge planners. This education will include valuable and relevant tools that can be used by case managers to convey proper information to patients and their families upon discharge.

3.1.2 Research Model Selection

A needs assessment design will be implemented for this research project. This design allows the researcher to determine whether issues common to the industry as identified in the literature were present among local hospital discharge planners. This needs assessment design will allow for collection of specific data before determining whether or not to expand the study or develop extensive intervention plans.

3.2 Description of the Intervention

The first intervention to implement will be to determine how the local hospital

industry compares to the industry at large as described in the literature. The literature described significant shortfalls with respect to discharge planning, which included poor communication between discharge planners and patients, a lack of systems to govern discharge protocols, and general ignorance about non-medical home care as a valid post-discharge care option among healthcare professionals. Because a considerable body of research exists pertaining to hospital discharge planning, much of the benchmark for comparing results of the research is already present in the literature review.

The second intervention will be to take the results of this pilot study to develop and replicate using a wider sample. Because of the nature of this study being a pilot study, shortcomings in methodology will be noted and adjusted for any larger study that follows. There is much anecdotal evidence to suggest that these industry shortcomings are present in the Southern California hospital market. The results of this study will provide the groundwork for a larger study. A larger study may benefit from this pilot study by providing possible inroads with hospitals who are less reluctant to participate because research has already been done on a small scale concerning the same issues.

The third intervention will be targeted in scope, but wide in scale, and will seek to provide data driven education to hospital case management departments. One way this education will be done is to work with hospitals to establish referral protocols in areas where they do not presently exist. Another is to provide education through "in-services" to hospital staff so they fully understand the different aspects of non-medical homecare. This will take a good deal of coordination, but by being able to highlight problems common to the region, curriculum and materials could be developed once and utilized to educate a number of hospitals. Because a discharge planner regularly comes into contact

with frail seniors needing assistance, proper education of this group of healthcare professionals can have wide impact on the quality of care seniors experience at home.

A fourth intervention will be to educate the senior population to the specific risks they may encounter if they do not also take responsibility for screening a homecare agency they hire. The main thrust of educating seniors can take place in three different ways including: educating community-based senior support services such as senior centers, reaching seniors and their families directly through the company's website and YouTube internet video channel, and providing educational presentations within the community at places such as churches, independent living facilities, etc. This intervention will equip patients and their families to advocate for themselves should they not be given proper tools by a hospital discharge planner following hospitalization.

3.3 Data Collection Plan

The needs assessment research design model is to be used for this study. Being a pilot study, the sample includes ten acute care hospitals located in the San Gabriel Valley. The specific participants contacted for response will be the directors of case management at each hospital. The only demographic distinction between the hospitals contacted will be determining the number of case managers that work in the department, as this may have some correlation to data provided in other questions. Data will be obtained through survey provided via email to each participant. This survey will be provided during the week of 4/21/2014, with response reporting ending at 5pm (Pacific Standard Time) 4/25/2014. Survey administration will be facilitated by Fluidsurveys.com, for reliability and ease of use. The data collection instrument was constructed based on what was discovered in the literature review. In addition, many of the questions were designed

using the Likert scale, gauging participants' understanding of the industry. In order to avoid the very real possibility of social desirability bias, questions were constructed to be as neutral as possible, or with a positive/negative counter-question to balance any biases. Once the surveys are completed and compiled, a test to determine correlation will be conducted using SPSS statistical software. Limitations to the survey include hospital case managers knowing the professional and ethical expectations placed on case management departments, and as a result, may answer questions based on an ideal, rather than reality. Another limitation would be limited response from those participants. Because this pilot study only has a sample size of ten hospitals, high participation is critical to the validity of the responses received.

CHAPTER 4: RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

Summary of Chapters 1, 2, and 3

The purpose of this research is to highlight problems found in the hospital discharge planning homecare referral process, and to provide context for the current state of the non-medical homecare industry in Southern California. The literature review revealed that non-medical home care is not currently licensed or regulated within California, and that there are wide variances in quality of service that aren't immediately clear to consumers who seek such services. Trusted sources of care-related information such as hospital case managers and social workers may unknowingly provide vulnerable seniors with referrals that may prove to be risky.

The literature pointed to four main areas. The first area described the role of non-medical homecare in the spectrum of care available to seniors needing assistance. The literature then showed that due to the unregulated state of the industry in California, families would unwittingly enter into risky legal and financial scenarios with caregivers hired into the home. The reviewed literature then spelled out the role of case-managers at hospitals and their important role with educating patients and their families with post-discharge instructions. The final aspects revealed by literature review were ample literature that highlighted barriers to proper referrals to care. Some of these hurdles include a lack of communication, standards or process when arranging for discharge; rushed discharges that lead to inadequate patient education and poor coordination of services; and referrers' ignorance of pitfalls and care options pertaining to post-discharge services.

The next component of this study was to develop the research strategy. The first part of this strategy was accomplished by establishing objectives, which included: using

the success of this pilot study to expand the scale in a subsequent study, as well as using the data collected to guide educational campaigns geared toward hospital discharge planners. Utilizing a needs assessment as a research model allowed for data analysis before determining whether or not to expand the study or develop extensive intervention plans. There were multiple interventions which included: determining how the local hospital industry compares to the industry at large as described in the literature, to take the results of this pilot study to develop and replicate using a wider sample, to provide data driven education to hospital case management departments, and to educate the senior population to the specific risks they may encounter if they do not take responsibility for screening a homecare agency they hire. The data collection plan included surveying directors of case management at ten acute care hospitals close to Azusa Pacific University. The data collection instrument was mostly designed using the Likert scale, gauging participants' understanding of the industry.

4.1 Summary of Results

The focus of this research study was to discover the referral practices and attitudes of acute hospitals within the San Gabriel Valley. Surveys were delivered to directors of case management at ten acute care hospitals via the internet. Responses were received for all ten hospitals surveyed. The completed survey results were analyzed using SPSS software, which provides a statistical analysis of the survey responses, such as frequencies, and statistical correlations.

Descriptive Tests

Using a descriptive T-test, it was shown that the hospitals surveyed ranged from having 49 to 453 patient beds, with a mean of 156.90 patient beds per facility surveyed.

The number of case managers per facility responsible for patient discharge education ranged from two to nineteen per facility, with a mean of 7.7 case managers per facility surveyed.

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Number of case managers	10	2	19	7.70	5.478
Number of patient beds	10	49	453	156.90	116.267
Valid N (listwise)	10				

When running a frequency test (exhibited below), hospitals appeared uncertain about whether or not non-medical homecare is licensed in California. Of the ten respondents to the question "Does state licensing currently exist for Non-Medical homecare services within California?", five (50%) responded "Probably not", three (30%) responding "Not Sure", and two (20%) responding "Probably", indicating some confusion as to the current regulatory status of homecare.

Is Non-Medical Home Care Licensed in CA?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Probably	2	20.0	20.0	20.0
	Not Sure	3	30.0	30.0	50.0
	Probably Not	5	50.0	50.0	100.0
	Total	10	100.0	100.0	

One surprising statistic (as shown in the graph below) was hospitals overwhelmingly use no set of tools to screen homecare agencies they refer to, with nine (90%) responding "Definitely Not", and one (10%) responding "Probably Not" when asked to respond to the statement "Your facility utilizes pre-determined screening tools in order to select non-medical homecare agencies to refer to." *(Scale: 1=Definitely,*

5=Definitely Not)

Does the facility screen the homecare agencies they refer to?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Probably Not	1	10.0	10.0	10.0
	Definitely Not	9	90.0	90.0	100.0
	Total	10	100.0	100.0	

A similar result showing a lack of screening was found when surveying how often hospitals provide patients with tools to screen homecare agencies, with eight (80%) responding "Never", one (10%) responding "Sometimes", and only one (10%) who replied "Often".

Provides patient with screening tools for HC?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Often	1	10.0	10.0	10.0
	Sometimes	1	10.0	10.0	20.0
	Never	8	80.0	80.0	100.0
	Total	10	100.0	100.0	

Respondents to the survey unanimously (100%) responded "Definitely" (shown in chart below) when asked to respond to the statement: "Your facility provides multiple care options to patients for post-discharge care." *(Scale: 1=Definitely, 5=Definitely Not)*

Does facility provide patients with multiple options for care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Definitely	10	100.0	100.0	100.0

Seeing that hospitals regularly provide multiple care options to patients, a follow-up question was " What information about non-medical homecare companies do you provide patients and families upon discharge?" The data shows (in figure below) that case managers primarily give patients a hospital prepared list (80%), with two (20%) not

responding to this question.

What HC info is given to families?

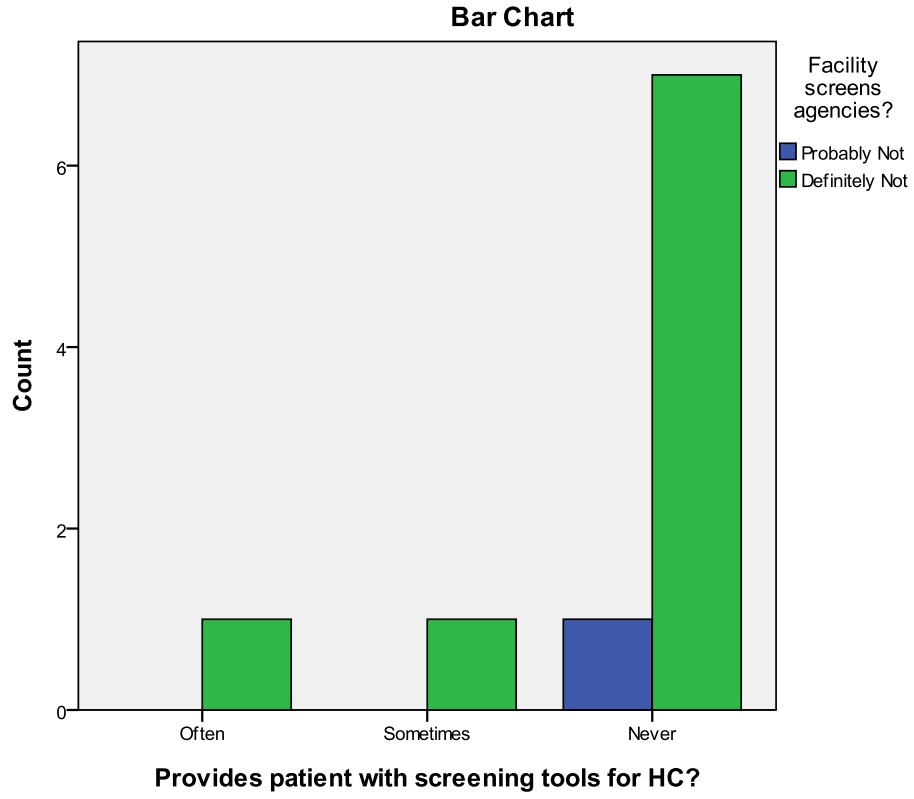
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hospital Prepared List	8	80.0	100.0	100.0
Missing	System	2	20.0		
Total		10	100.0		

Another result showing apparent hospital confusion pertained to the risk patients face when opting to use the services of a "registry". When asked for the level of agreement with the statement: "Families are exposed to legal and/or financial risks when hiring a caregiver through a registry", results showed three (30%) responding "Strongly Agree", five (50%) responding "Neutral", and two (20%) choosing "Disagree" (shown below). This 70% responding "Neutral" and "Disagree" shows a level of ignorance of the dangers known to exist for families when hiring through a registry.

Are Families exposed to risk through hiring through a Registry?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	30.0	30.0	30.0
	Neutral	5	50.0	50.0	80.0
	Disagree	2	20.0	20.0	100.0
	Total	10	100.0	100.0	

By using the crosstabs statistical test, some interesting comparisons emerged from the data. One interesting result showed that when crosstabulating the data of hospitals who provide patients with screening tools versus facilities who directly screen agencies, 7 (70%) of hospitals neither screen agencies, nor provide patients with tools to screen agencies. (shown in chart below)



One relationship highlighted by crosstabulation is the fact that eight (80%) of responding hospitals provide patients with hospital prepared lists, yet seven (87.5%) of the eight do not provide the patient with any tools to screen the agencies on that list.

Provides patient with screening tools for HC? * What HC info is given to families? Crosstabulation

Count

		What HC info is given to families?	
		Hospital Prepared List	Total
Provides patient with screening tools for HC?	Often	1	1
	Never	7	7
Total		8	8

Even more interesting is that of the eight (80%) responding hospitals that compile a list of agencies for patients to use, none of the eight (100%) screen the agencies they

add to the list they provide. (chart below)

What HC info is given to families? * Facility screens agencies? Crosstabulation

Count

		Facility screens agencies?	
		Definitely Not	Total
What HC info is given to families?	Hospital Prepared List	**8**	8
Total		8	8

Another interesting statistic that arose from crosstabulation pertains to the relationship between hospitals' understanding of home care being unlicensed in California and whether or not the hospital screens that agencies in light of that fact. According to the data, eight (80%) of respondents indicated that homecare is either "Probably Not" licensed (50%), or "Not Sure" (30%) if California requires licensure. In spite of this uncertainty about regulation existing for non-medical homecare, all eight (100%) either "Definitely Not" (87.5%) or "Probably Not" (12.5%) utilize any tools to screen the agencies to which they refer families. (shown in chart below)

Is Homecare Licensed in CA? * Facility screens agencies? Crosstabulation

Count

		Facility screens agencies?		
		Probably Not	Definitely Not	Total
Is HC Licensed in CA?	Probably	0	2	2
	Not Sure	0	**3**	3
	Probably Not	**1**	**4**	5
Total		1	9	10

Correlational Tests

Another set of tests was done to determine any correlation between different variables studied. There were a number of tested variables that showed statistical

significance and correlation, but were expected. One example of expected inverse correlation was shown when testing the relationship between physician preference strongly determining referred agencies versus discharge planners having full discretion in providing families with resources. This test showed a Pearson r correlation coefficient of -.786, which predictably shows that the more that physician preference plays a role in referrals, the less discharge planners' discretion in referrals.

Correlations between Physician preference and Discharge Planner Discretion

		Physician's role in referral?	Discharge Planner Discretion?
Physician's role in referral?	Pearson Correlation	1	-.786*
	Sig. (2-tailed)		.012
	N	9	9
Discharge Planner Discretion?	Pearson Correlation	-.786*	1
	Sig. (2-tailed)	.012	
	N	9	10

*. Correlation is significant at the 0.05 level (2-tailed).

Other relationships that showed statistical significance were less obvious. An example of unexpected correlation was the test that compared Discharge planners' discretion in referrals with hospitals' belief that" seniors prefer to receive care at home versus a nursing home during their senior years". In this case, the test showed a Pearson r correlation coefficient of .714. This strong relationship indicates that the more discretion a discharge planner has in facilitating discharge, the more a hospital agrees (and understands) that seniors prefer receiving care at home over a facility.

Correlations

		Discharge Planner Discretion?	Seniors pref Homecare vs. SNF
Discharge Planners Have Discretion?	Pearson Correlation	1	.714*
	Sig. (2-tailed)		.020
	N	10	10
Seniors prefer Homecare vs. Facility for care	Pearson Correlation	.714*	1
	Sig. (2-tailed)	.020	
	N	10	10

*. Correlation is significant at the 0.05 level (2-tailed).

It is interesting to note the inverse relationship between a physician's preference in discharge resources and that hospitals' agreeing that seniors prefer to receive care at home. This correlational test showed a negative Pearson r correlation coefficient of -.934, which is a very statistically significant relationship. This strong result was expected, as the literature reviewed clearly shows physician bias toward care in a nursing facility over other settings such as in the home.

A highly significant inverse (negative) relationship was discovered between knowledge of home care licensure in California and homecare resources being provided to patients. With a Pearson r correlation coefficient of -.811, this seems to indicate that hospitals that routinely provide families with information about homecare, know less about the industry's unregulated status than those that do not provide homecare information to patients as routinely.

One block of statistically significant relationships has appeared pertaining to hospitals' perceiving that registries pose risks to families. A couple areas tested against registry risk include: physicians' preference determining referrals, and a hospital acknowledging seniors' preference to receive care at home. Cases where hospitals'

physician preferences play a significant role in determining referral sources seem to have a highly significant correlation to hospitals perceiving the risks registries pose, with a Pearson r correlation coefficient of .882. This would suggest hospitals that perceive registry risk to patients also have physician preference largely dictate referrals to home care. Another very strong relationship is evident between hospitals' perceiving registry risk and hospitals acknowledging seniors' preference to receive care at home. This relationship is very strong with a Pearson r correlation coefficient of .800. This appears to mean hospitals that understand registry risk also have a high level of understanding seniors' clear desire to receive care at home.

One important result to note is that no statistically significant relationships were found between the number of case managers at each hospital or the patient bed count, and any other variable studied.

4.2 Conclusions

It is clear from the research conducted and data received that there are significant gaps in hospitals' knowledge and protocols, which leave seniors at risk. The study confirmed the problems identified in the literature review and bolster the need for a larger study and implementation of the interventions, now that need has been established. The study sample included a wide variety of hospital sizes and case manager counts, which had no statistical bearing on any of the areas surveyed. It is fairly safe to say that the deficiencies found among hospital discharge planning and case management departments with respect to homecare referrals are fairly universal regardless of hospital size or case manager count.

One area of particular concern centers on hospitals' apparent ignorance of non-

medical home care being currently unregulated in California. Non-medical home care for seniors is a service routinely referred to by hospitals. It is therefore surprising to discover such a significant lack of understanding in this important area of senior care, especially from case management departments that regularly interface with home care agencies. Because of the lack of state licensure, there are no standards which govern registries. In spite of this ignorance (or perhaps because of it), hospitals do little to nothing when it comes to objectively screening or evaluating agencies.

A lack of regulation in such an important field makes objective screening of agencies all the more important. Patients being discharged consider the discharge planner, and hospital by extension, to be knowledgeable and to provide them with care resources that will be help them. Unfortunately, the hospitals surveyed use no set of tools to screen the agencies to which they refer families. In addition, they provide the patient with no tools with which to screen the agencies whose information they are provided. While it is true that the hospital provides patients with multiple care options, most of the hospitals polled provide patients these resources on a hospital produced list, which carries with it an implicit hospital endorsement of the listed agencies' trustworthiness. To summarize this concern: the hospital provides the patient with a hospital prepared list of homecare companies; the hospitals don't screen agencies they add to the list, nor do they provide the patient with screening tools to avoid the legal and financial risks that come with hiring unscrupulous companies (who may be on the list provided).

The facet of this study that dealt with hospital understanding of registry risks yielded mixed results, with only three (30%) of hospitals responding with any level of agreement that "families are exposed to risk through registries". This is of particular

importance in the currently unregulated homecare industry, as registries can easily portray themselves as agencies with no validation needed. Because screening tools are not being employed, a lack of hospital vigilance on this issue is troubling, considering they are a primary source of referrals to the homecare industry.

The literature reviewed clearly shows that seniors prefer receiving care at home versus in a facility. The data obtained in this study showed significant differences pertaining to hospital attitudes on this issue. Attitudes were shown to be related to whether or not a hospitals discharge planners or physicians had greater discretion in referring patients to care in the home. The data shows that hospitals where physician preference plays a significant in referring patients to non-medical care do not agree that seniors prefer to receive care at home. This bias toward institutional care was well documented in the literature review. Conversely, hospitals where discharge planners have more (or full) discretion in arranging resources for patients largely believe that seniors prefer to receive care in the home. This distinction is important, as it points to systemic issues, where referrer preference may trump best patient outcomes.

Due to the fact that this study confirmed the problems listed in the literature, it would be fully prudent to expand this study to include a larger sample. In addition, because industry need has been clearly identified, proceeding with the interventions is very fitting. Because of the variety of hospitals surveyed and different demographics represented, it would be appropriate to generalize the study to include facilities in other geographic areas within California, and even other to states where licensing for non-medical homecare doesn't yet exist. Unless there are regional regulations that govern the non-medical homecare industry, statewide application of this data and interventions

makes sense.

4.3.1 Policy Recommendations

Based on the project results, the research supports moving forward with the remaining interventions, which include: develop and replicate this study using a wider sample, to provide data driven education to hospital case management departments, and to educate the senior population to the specific risks they may encounter if they do not take responsibility for screening the homecare agencies they hire.

Hospitals are referring to homecare companies every day in California, and based on the research, lax hospital screening procedures are placing countless seniors in jeopardy. In order to get a sufficiently accurate result for generalization, it will be important to expand the sample size of this study to include additional facilities from additional geographic areas. This expansion of the sample will allow for factors unique to other regions within the state to be represented and accounted for in the expanded study. There ought to be additional geographic questions added to the survey to account for any differentiation in data based on region. Because this pilot study has provided compelling data about the problem within the California hospital referral market, otherwise reluctant hospitals may be more willing to participate.

Immediate work can be done to produce and implement education to hospital case management departments, as well as to the physician population in hospitals. Because there is much confusion about the types of care options and dangers within the non-medical homecare industry, it will be important to address the primary issues uncovered within this study. The topics for hospital education will include: the current lack of licensure within California, the difference between agencies and registries, provide

hospitals with basic screening tools so they can better provide their patients with resources, and educate physicians on seniors' preference to receive care at home vs. facility. One addition to this intervention is taking the existing list provided by hospitals and properly categorizing agencies and registries, and including basic information on the differences between the two categories. Another component of this intervention is to create and provide hospitals with a screening tool to make available to all patients upon discharge. This way, even if the patient isn't provided with, or ignores, a hospital list, they will have the means to differentiate between companies they contact.

Hospitals should be an excellent place to effect change in this area of patient and senior education. In spite of hospitals' responsibility for education, seniors and their families must also have access to information about non-medical homecare companies and how to properly differentiate between them. Educating seniors is much more time intensive and broader in scale than educating hospitals. In spite of the required effort, educating seniors about this topic is important, especially as the senior population grows. Education can happen in at least three main ways: educating community-based senior support services such as senior centers, leveraging technology to reach seniors and their families directly through a YouTube internet video channel with posting this information on senior related websites for visibility, and providing educational presentations within the community at places such as churches, independent living facilities, etc. Educating the end users of home care services is important because not every senior seeks out services through a hospital, and once educated, can serve to be a source of information for their peers.

Each of these interventions can happen concurrently once all are initiated. First

implemented will be the expanded study. The results of this expanded study will inform the educational push to hospitals, and may also create the opportunity for contacts within the hospital organization who may be more receptive to education once they participate in a study and see the results. Finally, direct education of seniors can be implemented once more widespread hospital referral and education practices are ascertained.

4.3.2 Recommendations for Further Research

The large amount of literature on the subject of senior care and non-medical homecare pitfalls within the unregulated industry proved to be helpful in creating an effective data collection tool. As the study is expanded to include more participants, it might be helpful to include questions that gauge systemic barriers to proper referrals. One option could try to probe the respondent's opinion on wider system issues, such as failed past attempts at creating screening tools for homecare. Another option could be to seek data on hospital preference for screening tools or educational information, as this will inform future education efforts.

As this study demonstrated, there are significant, widespread shortcomings when it comes to hospital referral procedures for non-medical home care. With little attention being paid to the quality of agencies being recommended, hospitals may be inadvertently placing seniors in harm's way upon their discharge from the hospital. Because the literature was so clear about the risk that registries pose to families, it is crucial that hospitals become educated on this topic, because of the significant influence they have on the care decisions of patients. Seeking to provide effective education to these hospitals so that they can better fulfill their ethical and professional responsibility will create an

environment where seniors are given the tools to receive the best care possible, in a setting that best meets their needs.

References

Communication with home care staff part of transition: problems may arise during transition. (2009). *Healthcare Benchmarks & Quality Improvement, 16*(3), 34-36.

Eija, G., & Marja-Leena, P. (2005). Home care personnel's perspectives on successful discharge of elderly clients from hospital to home setting. *Scandinavian Journal of Caring Sciences, 19*(3), 288-295.

Ensure patients, families informed after discharge: offer all options, including private duty services. (2010). *Case Management Advisor, 21*(5), 54.

Golden, A. G., Martin, S., da Silva, M., & Roos, B. A. (2011). Care Management and the Transition of Older Adults From a Skilled Nursing Facility Back Into the Community. *Care Management Journals, 12*(2), 54-59.

Make sure patients are appropriate for home care. (2009). *Hospital Case Management, 17*(2), 27-28.

McMackin, S. (2006). What is private-duty home care? An industry overview. *Home Health Care Management & Practice, 18*(2), 92-97.

Milligan, J. (2006). The accidental employer: obligations of trusts and/or trustees when using placement agencies to meet trust obligations. *Home Health Care Management & Practice, 18*(2), 109-113.

Nosbusch, J., Weiss, M., & Bobay, K. (2011). An integrated review of the literature on challenges confronting the acute care staff nurse in discharge planning. *Journal of Clinical Nursing, 20*(5-6), 754-774.

O'Doherty, M. (2006). Lessons learned: a case study. *Home Health Care Management & Practice,* 103-105.

Orsini, M. (2006). Marketing private-duty home care services. *Home Health Care Management & Practice, 18*(2), 114-123.

Reder, S., Hedrick, S., Guiham, M., & Miller, S. (2009). Barriers to home and community-based service referrals: the physician's role. *Gerontology & Geriatrics Education, 30*(1), 21-33.

Smith, C. (2006). The National Private Duty Association: making strides in the home care industry. *Home Health Care Management & Practice, 18*(2), 106-108.

Socol, C. (2006). Protecting consumers from the pitfalls of home care. *Home Health Care Management & Practice, 18*(2), 98-102.

Wipfli, B., Olson, R., Wright, R. R., Garrigues, L., & Lees, J. (2012). Characterizing Hazards and Injuries Among Home Care Workers. *Home Healthcare Nurse, 30*(7), 387-393.

Appendix A

Data Collection Tool - Survey questions

1. How many patient beds does your facility have? *(Numerical entry)*
2. How many case managers and/or discharge planners are responsible for direct patient discharge education in your facility? *(Numerical entry)*
3. To the best of your knowledge: Does state licensing currently exist for Non-Medical homecare services within California? *(Scale: 1=Definitely, 5=Definitely Not)* 1 2 3 4 5
4. How much do you agree?: Physicians preference plays a significant role in referring patients to non-medical homecare services. *(Scale: 1=Strongly Agree, 5=Strongly Disagree)* 1 2 3 4 5
5. How much do you agree?: Discharge planners at your facility have full discretion in what resources are provided to patients and families. *(Scale: 1=Strongly Agree, 5=Strongly Disagree)* 1 2 3 4 5
6. How much do you agree?: Case managers at your facility have adequate time to communicate discharge information and resources to patients and families. *(Scale: 1=Strongly Agree, 5=Strongly Disagree)* 1 2 3 4 5
7. How much do you agree with this statement: "Seniors prefer to receive care at home versus a nursing home during their senior years." *(Scale: 1=Strongly Agree, 5=Strongly Disagree)* 1 2 3 4 5
8. How accurate is this statement?: Your facility utilizes pre-determined screening tools in order to select non-medical homecare agencies to refer to**.** *(Scale: 1=Definitely, 5=Definitely Not)* 1 2 3 4 5
9. How accurate is this statement?: Your facility provides multiple care options to patients for post-discharge care. *(Scale: 1=Definitely, 5=Definitely Not)* 1 2 3 4 5
10. How accurate is this statement?: Your facility provides patients and families with information for non-medical homecare upon discharge. *(Scale: 1=Definitely, 5=Definitely Not)* 1 2 3 4 5
11. What information about non-medical homecare companies do you provide patients and families upon discharge? *(Choices: Hospital prepared list, Agency brochures, Word of mouth Other, please specify)* 1 2 3 4 5

12. Please indicate frequency: Upon discharge, your facility provides patients with tools to screen the non-medical homecare companies they contact. *(Scale: 1=Always, 5=Never)* 1 2 3 4 5
13. How accurate is this statement?: Your facility has written protocols in place that dictate the types of resources provided to patients and families upon discharge. *(Scale: 1=Definitely, 5=Definitely Not)* 1 2 3 4 5
14. Which of the following actions by a homecare agency plays the biggest role in determining that agency's information being provided to families? *(Choices: Frequency of agency rep visits to facility, Agency's reputation/Perceived quality, Agency is contracted with facility for referrals, Printed materials made available by agency, Other, please specify...)*
15. How accurate is this statement?: Your facility provides patients with information about the differences between homecare "Agency" and homecare "Registry" options. *(Scale: 1=Strongly Agree, 5=Strongly Disagree)* 1 2 3 4 5
16. How much do you agree with the following statement? "Families are exposed to legal and/or financial risks when hiring a caregiver through a registry." *(Scale: 1=Strongly Agree, 5=Strongly Disagree)* 1 2 3 4 5
17. To the best of your knowledge, for which of the following might a family become responsible if hiring an independent contractor from a homecare registry? *(Choices: Unemployment payments, Workers Compensation payments, Social Security Withholding, Payroll tax withholding, All of the above, None of the above)*

Appendix B:

Correlations

		Number of case managers	Number of patient beds	Is HC Licensed in CA?	Physician's role in referral?	Discharge Planner Discretion?	Case managers have time?	Seniors pref Homecare vs. SNF	Facility screens agencies?	Provides multiple options for care?	Homecare info provided on D/C?	Provides patient with screening tools for HC?	Written protocols determine resources given?	Agency action that leads to referrals?	Facility provides info Agency vs. Reg?	Are Families are exposed to risk through Reg?
Number of case managers	Pearson Correlation	1	.664*	.416	.371	.057	-.036	-.424	-.212	.a	-.304	-.498	-.309	.428	.502	.221
	Sig. (2-tailed)		.036	.231	.325	.876	.922	.222	.557	.	.426	.143	.386	.217	.139	.539
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Number of patient beds	Pearson Correlation	.664*	1	.104	.388	-.250	-.257	-.365	.169	.a	-.258	-.090	-.214	.198	.480	.268
	Sig. (2-tailed)	.036		.776	.303	.486	.474	.300	.641	.	.503	.805	.553	.583	.160	.453
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Is HC Licensed in CA?	Pearson Correlation	.416	.104	1	-.526	.620	.604	.509	-.299	.a	-.811**	-.187	-.544	.508	.696*	-.667*
	Sig. (2-tailed)	.231	.776		.146	.056	.065	.133	.402	.	.008	.604	.104	.134	.025	.035
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Physician's role in	Pearson Correlation	.371	.388	-.526	1	-.786*	-.300	-.934**	-.169	.a	.504	-.070	.438	-.141	.195	.882**

referral?	Sig. (2-tailed)	.325	.303	.146		.012	.433	.000	.665	.	.203	.859	.238	.717	.616	.002
	N	9	9	9	9	9	9	9	9	9	8	9	9	9	9	9
Discharge Planner Discretion?	Pearson Correlation	.057	-.250	.620	-.786*	1	.346	.714*	.156	.a	-.539	-.229	-.663*	-.116	-.074	-.673*
	Sig. (2-tailed)	.876	.486	.056	.012		.328	.020	.667	.	.134	.525	.037	.751	.839	.033
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Case managers have time?	Pearson Correlation	-.036	-.257	.604	-.300	.346	1	.327	-.048	.a	-.087	.209	.172	.308	.529	-.693*
	Sig. (2-tailed)	.922	.474	.065	.433	.328		.357	.896	.	.824	.562	.635	.387	.116	.026
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Seniors pref Homecare vs. SNF	Pearson Correlation	-.424	-.365	.509	-.934**	.714*	.327	1	-.040	.a	-.472	.294	-.542	-.024	-.028	-.800**
	Sig. (2-tailed)	.222	.300	.133	.000	.020	.357		.912	.	.199	.410	.106	.947	.938	.005
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Facility screens agencies?	Pearson Correlation	-.212	.169	-.299	-.169	.156	-.048	-.040	1	.a	.164	-.163	.190	-.516	-.342	-.120
	Sig. (2-tailed)	.557	.641	.402	.665	.667	.896	.912		.	.673	.653	.599	.127	.334	.742
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Provides multiple options for care?	Pearson Correlation	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a
	Sig. (2-tailed)	.	.	.	.	.	.	.	.		.	.	.	.	.	.

	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Homecare info provided on D/C?	Pearson Correlation	-.304	-.258	-.811**	.504	-.539	-.087	-.472	.164	.[a]	1	.242	.854**	.207	-.616	.242
	Sig. (2-tailed)	.426	.503	.008	.203	.134	.824	.199	.673	.		.530	.003	.594	.077	.530
	N	9	9	9	8	9	9	9	9	9	9	9	9	9	9	9
What HC info is given to families?	Pearson Correlation	.[a]	.[a]	.[a]	.[a]	.[a]	.[a]	.[a]	.[a]	.[a]	.[a]	.[a]	.[a]	.[a]	.[a]	.[a]
	Sig. (2-tailed)	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	N	8	8	8	7	8	8	8	8	8	7	8	8	8	8	8
Provides patient with screening tools for HC?	Pearson Correlation	-.498	-.090	-.187	-.070	-.229	.209	.294	-.163	.[a]	.242	1	.155	.033	.038	-.175
	Sig. (2-tailed)	.143	.805	.604	.859	.525	.562	.410	.653	.	.530		.670	.928	.916	.628
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Written protocols determine resources given?	Pearson Correlation	-.309	-.214	-.544	.438	-.663*	.172	-.542	.190	.[a]	.854**	.155	1	.072	-.115	.205
	Sig. (2-tailed)	.386	.553	.104	.238	.037	.635	.106	.599	.	.003	.670		.842	.752	.570
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Agency action that leads to referrals?	Pearson Correlation	.428	.198	.508	-.141	-.116	.308	-.024	-.516	.[a]	.207	.033	.072	1	.588	-.314
	Sig. (2-tailed)	.217	.583	.134	.717	.751	.387	.947	.127	.	.594	.928	.842		.074	.377
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10

Facility provides info Agency vs. Reg?	Pearson Correlation	.502	.480	.696*	.195	-.074	.529	-.028	-.342	.a	-.616	.038	-.115	.588	1	-.226
	Sig. (2-tailed)	.139	.160	.025	.616	.839	.116	.938	.334	.	.077	.916	.752	.074		.529
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Are Families are exposed to risk through Reg?	Pearson Correlation	.221	.268	-.667*	.882**	-.673*	-.693*	-.800**	-.120	.a	.242	-.175	.205	-.314	-.226	1
	Sig. (2-tailed)	.539	.453	.035	.002	.033	.026	.005	.742	.	.530	.628	.570	.377	.529	
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
What risks when hiring IC from registry?	Pearson Correlation	.050	.100	-.735*	.676*	-.526	-.504	-.805**	.404	.a	.459	-.437	.510	-.464	-.419	.766**
	Sig. (2-tailed)	.892	.783	.016	.046	.118	.138	.005	.248	.	.213	.207	.132	.177	.228	.010
	N	10	10	10	9	10	10	10	10	10	9	10	10	10	10	10
Any added thoughts from participant	Pearson Correlation	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a	.a
	Sig. (2-tailed)	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

*. Correlation is significant at the 0.05 level (2-tailed).

a. Cannot be computed because at least one of the variables is constant.

**. Correlation is significant at the 0.01 level (2-tailed).