

QUICK FACTS

Hawaii's Person-Centered Hospital Discharge Model (HDPM)

The Executive Office on Aging was recently awarded a grant from the Centers for Medicare & Medicaid Services (CMS) to develop a Person-Centered Hospital Discharge Planning Model and expand/enhance the Aging and Disability Resource Center (ADRC) Program. CMS and AoA funded these grants for states to develop hospital discharge models that

- put the patient and caregiver(s) at the center of the discharge planning process;
- focus on discharging patients to home and community-based services (HCBS), via the Aging and Disability Resource Center (ADRC);
- reduce the number of patients retained in acute care beds past the point of clinical discharge; and
- reduce the number of default discharges from acute care units to nursing facilities

In addition, the ADRC will be expanding to include the islands of Kauai and Maui and a physical site within the City and County of Honolulu in Kahuku.

Federal Grant Award to the State: \$1,167,000 Total

Grant period: July 1, 2009 –September 29, 2012 (39 months)

HDPM Target population: Medicaid-eligible individuals discharging from a hospital stay

Initial Pilot locations: Acute care hospitals in all four Planning and Service Areas

- Kauai Veterans Memorial Hospital – with 21 acute and 4 ICU beds
- Kahuku Medical Center – with 11 acute/SNF (swing) beds
- Maui Memorial Medical Center – with 185 acute beds
- North Hawaii Community Hospital – with 39 acute beds

Key partners:

- Hawaii's four Area Agencies on Aging (AAAs)
- Department of Human Services – the single state Medicaid agency
- Hospitals
- Healthcare Association of Hawaii

Project goals:

- Develop a hospital discharge planning model that meaningfully engages and solicits patient input and participation and maximizes the opportunity for Medicaid patients to return home with HCBS upon discharge
- Establish a highly visible and trustworthy fully functioning Aging and Disability Resource Center that is easily accessible to the public and responsive to their needs for information and linkages to long term care options
- Streamline the screening, intake, assessment and eligibility determination to reduce redundancy of paperwork, confusion and frustration in accessing long term supports.

Outcomes:

- Within the first 18 months, the partners will collaboratively design and develop a person centered discharge planning model plus its associated tools, procedures and protocols
- Discharge of Medicaid patients to nursing facilities, and associated costs, will be reduced; discharges to home, with HCBS, will increase
- Hospital discharge planners and other critical pathway providers will be educated about ADRC, and will make appropriate referrals
- Customer satisfaction rating will be 90% or higher related to discharge planning process and caregiver education

Project Timeline

CMS stipulated that the grant activity be carried out in two 18-month phases. During Phase I we are to develop and refine our Person-Centered Hospital Discharge Planning Model as well as any assessments, procedures and tools we plan to use. During Phase II we are to implement our model and analyze the results of our efforts to improve and expand the discharge planning process. Below are the key tasks we plan to complete during each phase.

Development phase:

- Secure a statewide Project Coordinator and a Systems Change Developer at EOA
- AAAs will assign or secure their local project coordinators to work with local hospitals, key partners, and the statewide project team
- Create a statewide Development Team that includes key partners, stakeholders and consumers
- Create task teams to develop specific assessments, procedures and tools
- Solicit feedback and buy-in from stakeholders
- Create required narrative reports for CMS & AoA

Implementation phase:

- Implement the proposed model at the initial hospital locations
- Evaluate effectiveness of model and adapt as needed
- Recruit additional hospital locations for implementation
- Create required narrative and data reports for CMS and AoA

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