

HPPAE Happenings

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Fall 2009



Welcome new HPPAE students!

By Davida Nugiel, Rutgers University HPPAE Alumni

Fall has always been a season for new beginnings, fresh starts empowered by renewed strength and commitment that often follows time away. As the crisp weather infuses us with energy, our minds snap awake. Returning to the university after just a summer off, or perhaps walking through the campus for the first time in many years, college students around the country are returning with hope, expectations and interest.

Those of us in the world of gerontology have a special world awaiting us. Never before has the field of gerontology held so many options calling for creative solutions. As we as a nation age in droves, new situations arise daily calling for answers. As ever advancing technology in the medical profession provides new successful treatments for many conditions and diseases, as well as information and direction on maintaining our health and wellness as we age, we are living longer and healthier.

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STAY CONNECTED!

Join the listserv:

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Be a friend on www.myspace.com/swli or



Healthcare Reform and Older Adults

By Rachel Gill, University of Texas, Austin HPPAE Alumni

Health care reform legislation is now being debated in Congress, by TV pundits, at town hall meetings, around dinner tables and on street corners. There is still uncertainty surrounding the form this legislation will take. No matter what form the legislation takes it will undoubtedly impact the millions of older adults enrolled in Medicare programs. Congressional budget estimates conclude that Medicare Part A funding could be depleted by 2017. One aim of the legislation is to boost Medicare programs by cutting excess spending. If this spending is not reduced Medicare funds will be exhausted in the near future. In order for older adults

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University of North Carolina, Chapel Hill;
University at Albany

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Society is called upon to match this pace of change and find new and creative solutions for the ever increasing aging population. The third stage of life is now considerably longer than the few brief years of generations past, and we in the gerontology profession have the supreme challenge of making these years purposeful, enjoyable and dignified. It is an honorable, exciting and extremely rewarding profession.

The alumni and staff of the Hartford Partnership Program for Aging Education would like to take this opportunity to welcome all returning fellows and students, as well as the new students entering the profession. The road ahead is glistening with opportunities today for you to think, create, and shape a better tomorrow for our society. May we all have a wonderful year!

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An Introduction to Medicaid Waiver Programs



By Amanda Ripke, University of Ohio HPPAE Alumni

In 1999 the U.S. Supreme Court issued decision in the *Olmstead v. L.C.* case. This case involved the state of Georgia's attempt at institutionalizing two women with mental illness, despite the opinion of treatment professionals that the women were capable of living in the community. The *Olmstead* decision mandates states administer programs and services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Essentially, the Court ruled that the segregation of people with disabilities in an institutional setting, when successful community placement is viable, is a form of discrimination.

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to be able to continue to depend on and utilize Medicare programs in the future, some type of health care reform is needed.

America's Affordable Health Choices Act introduced in the House as HR 3200 outlines changes to the Medicare reimbursement structure in the form of both reductions for preventable hospital readmissions from skilled nursing facilities and reimbursement increases and incentives for preventative primary care visits. Reduction of spending on unnecessary testing, and eliminating the Medicare Part D coverage gap are also a goals of the legislation.

In an effort to make health care reform cost effective over time, the reductions should create a surplus in funds to balance out the increases and to continue to fund the program going forward. Criticisms regarding the above Medicare impacts have centered on cutting of funding to skilled nursing centers and reductions in reimbursement for medical testing. Individuals want the most comprehensive and best care available to them when they need it; however, the best care is not always *more* care. Care delivered more deliberately with an eye towards prevention of illness or further complications and positive outcomes would be the *best* care. The focus on having all care available at all times has influenced the dissenting voices regarding another aspect of the legislation impacting older adults: the end of life planning stipulation.

As outlined in the legislation, this end of life planning conversation would be between doctor and patient, and the doctor would be able to bill Medicare for the time involved in the visit. The legislation does not encourage doctors to counsel patients to refuse care nor does it require that they conduct advance care planning consultations; it only allows doctors to

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The primary means through which states meet the needs of those with disabilities living in the community are Home and Community Based Services (HCBS) waivers. These waivers are administered on a state by state basis, and provide in-home services, case management, caregiver respite, and medical intervention to those who otherwise would be living in an institutional setting such as a nursing facility.

The services administered through these waiver programs cannot exceed the cost of institutional care, and on average, actually cost a great deal less than the institutional standard. While the eligibility criterion for these programs do vary slightly across states, the general requirements include Medicaid eligibility (standards are different for those applying for HCBS programs than those applying for community Medicaid) and a minimum level of care need (based on ADL and IADL assistance).

An example of an HCBS program is Ohio’s Pre-admission Screening System Providing Options and Resources Today (PASSPORT). Individuals eligible for the PASSPORT Program must be age 60 or over, financially eligible for Medicaid institutional care, require a nursing home level of care, and are able to live safely at home as determined by their primary physician. Ohio’s PASSPORT Program provides a wide array of services to assure the maintenance of health and safety, services such as: personal care, home delivered meals, caregiver respite, adult day services, transportation, and case management.

Programs such as PASSPORT enable older adults the choice of where they will receive needed care. Programs providing this choice honor the Olmstead decision and assure individuals with physical, developmental, or mental disabilities are not helpless in the decisions about their care, but rather, empowered to live safely in their own home.

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be reimbursed for the service if they provide the consultation and defines what must be included in a consultation if one is conducted, including options available to the patient at the end-of-life. Those options always include providing the maximum care possible, providing comfort care only, or some combination of the two preceding options. Of course the decisions and nuances of any individual’s condition and wishes are much more complicated than that, thus the need for the doctor to take the time to have a conversation with the patient. Providing reimbursement to the doctor for taking the time to have the conversation with the patient provides recognition for the time and skill involved in assisting someone in understanding their options and making the best decision they can make for themselves as an individual. The legislation allows for reimbursement for one consultation per Medicare beneficiary every 5 years, or more frequently in the case of a significant change in condition or a terminal diagnosis.

As social workers, we are often the professionals tasked with guiding individuals through end-of-life decision making, advance directive planning, resource management and assisting them in finding appropriate care. If health care reform is delayed, we can expect dwindling Medicare dollars to adversely impact the lives of our older adult clients. If we as a society continue to ignore the need to discuss end-of-life issues, people will continue to die uninformed about their options and possibly in situations they would not have chosen for themselves spending unnecessary health care dollars in the process. Although it is unclear what structure the health care reform legislation will take, it is clear that some type of reform is needed.

For more information on current health care reform proposals and their impact on older adults:

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For more about HCBS Programs in your state:

<http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp>

For access to research on HCBS Programs:

<http://www.hcbs.org/>

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Caregiver's Guide to Discharge Planning

By Lucy Siegel, University at Albany
HPPAE Alumni

When your loved one is admitted to a hospital, you will be approached by a number of people; admission clerks, nurses, doctors, and more.

What may surprise you is that a discharge planner will also come to speak with you. This is not because you are being rushed out of the hospital; rather it is because the best time to start planning for discharge is within a day or two of hospitalization. The discharge planner is there to facilitate the continuity of health care between hospital stay and return to the community. Whether the discharge plan is to return home or transfer to another level of health care, the discharge planner is there to make this transition as smooth as possible. In addition, a successful discharge plan can help prevent rehospitalization.

Developing a successful plan requires collaboration between you, your loved one (the patient) and the medical team. Being discharged from the hospital does not mean that your loved one is fully recovered and able to take care of him or herself. It just means that he/she is stable and no longer needs hospital level care. It is, therefore, important that you know what to expect when your loved one leaves the hospital. Will he/she be going home with no further need of services?

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<http://www.kff.org/healthreform/sidebyside.cfm>

<http://www.healthreform.gov/reports/seniors/seniorsreport.pdf>

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Update: At the time this article was written, the "end of life provision" was still in the House bill; however advance care planning and end-of-life provisions were not included in the health care reform bill considered by the Senate Finance Committee,

<http://thehill.com/homenews/senate/54617-finance-committee-to-drop-end-of-life-provision>

2009 HPPAE Graduates



University of North Carolina, Chapel Hill



University at Albany

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need of services? Will they require someone to be with them at all times? Will they need services at home or go to another health care setting (i.e. rehabilitation)?

You will need to provide the health care team with information about your loved one's home situation and the ability of the family to provide assistance. You will need to be candid with the medical team about the family's ability to provide care as well as any problems in the home that would make a discharge to home unsafe.

If you cannot provide a safe environment, it may be best for your loved one to spend time in a rehabilitation facility. It is especially important that you understand what medications your loved one will be taking and how it should be administered. If you feel nervous about medication or treatment issues, ask if the discharge planner can arrange for a visiting nurse to come and review the medications and treatments with you once your loved one is released from the hospital.

One of the best ways to prepare for hospitalization and the discharge talk is to keep a notebook with a complete medical history. This will make it easier to answer questions about your loved ones medical and personal history (this is also handy for doctor appointments). Make sure the history includes names of all doctors your loved one sees, a list of all medication, and dates of any medical procedures and the reason for the treatment. Include a brief history of your loved one, such as date and place of birth, whether parents and siblings have/had any significant medical conditions, etc. Also make notations any time you notice a change in your loved ones functional abilities and the dates of those changes. You can also use this notebook to keep track of information you receive from doctors at the hospital. One note about appealing a hospital discharge decision. Your medical team's goal is to help you develop a discharge plan that meets the medical

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Call for Papers and Posters HPPAE e-journal, GENERATIVITY!

Deadline: December 1, 2009

GENERATIVITY: *Advances Social Work Leadership in Aging* is a bi-annual online, national, peer-reviewed journal dedicated to the publication of Hartford Partnership Program for Aging Education (HPPAE) student and alumni research.

The purpose of the journal is two-fold:

- 1) To foster and reward scholarly efforts of HPPAE graduates as well as to provide a valuable learning experience;
- 2) Create a vehicle to contribute knowledge for advancing social work leadership in aging.

The opportunity for HPPAE alumni and students to publish in a national journal is not only a contribution to the profession, but adds value to your individual self-discovery and leadership development.

For submission instructions, please go to <http://socialworkleadership.org/nsw/students/ejournal.php>

Acknowledgements to CLIA members of the Journal working group:

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and safety needs of your loved one. If you disagree with the plan, you have the right to appeal. The appeal process can vary depending on insurance, but the discharge planner can help you find the correct process. A formal appeal can be complicated so it is always best to resolve your concerns with your medical team. Overall, the best way to avoid discharge issues is to stay involved with your medical team and discharge planner throughout your loved one/s hospitalization.

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THIS NEWSLETTER IS BROUGHT TO YOU BY THE COMMITTEE ON LEADERSHIP IN AGING

The *HPPAE Happenings* is a tri-annual newsletter and one of various ways that the committee will work to strengthen the network of HPPAE students, alumni and social work professionals in the aging area.

Acknowledgements to the Newsletter work group:

Cindy Arispe and Hope Burnette Melton (co-conveners), Jess Bartlett, Nicole Back, Tammie Morley, Jessica Myers, Davida Nugiel, and Mary Sheridan.



Not sure how to get to CSWE?

**VOLUNTEER for
FREE REGISTRATION!**

<http://www.cswe.org/CSWE/meetings/annualmeeting/Student+Volunteers+Call.htm>

HPPAE students or alumni attending CSWE-APM?

These sessions are not to be missed!

Saturday, November 7th

5:30 - 7:30 pm – HPPAE Awards Ceremony and Reception, Lonestar Ballroom Salon C

Sunday, November 8th

9:30 - 2:00 pm – HPPAE Student and Alumni Leadership Workshop, Grand Hyatt Independence. Free, no CSWE registration necessary. Includes lunch. Space is limited. Please RSVP to Jarmin Yeh, jyeh@nyam.org.

Monday, November 9th

1:30 - 3:00 pm – Becoming Aging-Competent Leaders: Voices of HPPAE Graduates, Grand Hyatt Travis C, Nina Abiera (USC), Cindy Arispe (U. of Houston), Melanie Bryant (Widener), Ashley Mader (Widener)