Hospital to Home

San Luis Obispo Caregivers
A Referral Agency

www.slocaregivers.com
(805) 748-2614

Your guide to a safer and smoother discharge and transition from a hospital or skilled nursing/rehabilitation facility to care at home.

Introduction and Process

Feeling lost? It is easy to feel this way when your parent is admitted into the hospital. You are probably dealing with a lot of new information and balancing your own work and family life in the process. We know it is not easy.

We put together this guide to help you navigate the general process of getting discharged from a hospital or a post-hospitalization skilled nursing or rehabilitation facility. The discharge process is largely the same amongst all the different types of facilities.

It is helpful to understand the process; the personnel involved and how they can best participate to make the transition more successful. Surprise! The discharge often comes much sooner than you expect, so a little preparation can go a long way to reduce an already stressful situation. Hospital stays are getting shorter and shorter so preparing early for your transition home is crucial to recovery and helps prevent

Know Your Team

Supportive Family and Friends

Many times there can be several family members involved in the process of helping out. It is important to choose one point person (family, relative or friend) that acts as the coordinator for all parties because patients themselves are often incapable of successfully coordinating discharge and post-hospitalization care. If you are reading this guide, it is likely that you will play a primary role in coordinating not only care in the hospital but also the transition home. Working cooperatively with hospital personnel will help to ensure the best care for your loved one and a successful transition home.

Our Family Planner is _____

Patients Name _____

Medical Condition of patient (in general terms) _____

_____

_____

_____

_____

In your own words describe your family care situation (your concerns)

_____

_____

_____

_____

_____

_____

Different roles of the Hospital or Skilled Nursing Staff

01

Typically a Social Worker or Nurse Case Manager, the discharge planner acts as the liaison between the hospital, the patient and their family through the discharge process. Their role encompasses balancing the needs of the patient with the requirements of insurance companies, Medicare and the hospital or rehab facility. They further assist in setting up post hospitalization services such as home care, home health and hospice.

Discharge Planner

Our Discharge Planner is: _____

02

The Nurse Case Manager is responsible for internally coordinating a patient's care during their time in the facility. They collaborate with colleagues and inform Medicare and insurance companies about changes in care to ensure payment to the hospital and avoid financial problems for patients.

Nurse Case Manager

Our Nurse Case Manager is: _____

03

It used to be that your primary physician made rounds at the hospital to check in on their patients. Today, however, hospitals have their own physicians that work at the hospital (sometimes referred to as hospitalists) overseeing patient care during the patient's stay.

Attending Physician or Hospitalist

Our Attending Physician is: _____

04

Nurses play a very crucial role in your loved one's care! They are usually on the front line of providing care and are an excellent source of information regarding the patient's condition, day-to-day progress, and continuity of care.

Nursing Staff

Our Key Nurses Are: _____

Social Worker

Social workers often educate patients and their families on community resources available for psychotherapy, grief counseling, and other supportive measures during and after the hospital stay. Their primary focus is assessing the patient relative to their mental health and social support structure. They can also be an effective mediator for families that may be in disagreement about care issues. They will often be the person responsible for discharges in Skilled Nursing Facilities.

Our Social Worker is: _____

Therapists

These professionals often play a huge role in the recovery and rehabilitation at the hospital, rehab facility and post hospitalization. Depending on the reason for hospitalization their involvement will vary.

Occupational Therapist (OT)

Primary role is to evaluate a patient's physical and cognitive abilities to perform normal activities of daily living like walking, eating, bathing and writing. They design programs to help patients achieve their goals related to independence in performing these tasks.

Physical Therapist (PT)

Primary role is to work with patients who have limitations or changes in physical or mental function resulting from injury, disease, or other causes. This work includes examination, evaluation, diagnosis and interventions toward achieving the highest functional outcomes.

Speech Therapist (ST)

Primary role is to evaluate, diagnose and provide rehabilitation for speech, language, cognitive-communication and swallowing disorders.

Our OT is: _____ Our PT is: _____ Our ST is: _____

Other Parties

Skilled Nursing or Rehabilitation Facility

The hospital care team may strongly recommend going to a skilled nursing facility upon hospital discharge to further recover before going home. Discuss your options with your discharge planner.

Medicare or Health Insurance Provider

These organizations play a large role in providing parameters and authorization for care. Nurse case managers and discharge planners work closely to obtain these authorizations.

Home Health Care Agency

These organizations provide nursing and skilled therapy services at home after hospital or rehabilitation facility stays. These services are typically covered by Medicare or supplemental insurance, but are usually authorized for only a limited time frame of generally 2-6 weeks.

Home Care Agency

These organizations provide non-medical senior care performing the Activities of Daily Living (ADL) which include cooking, cleaning, dressing, bathing, grooming, toileting, medication reminders, transportation and a number of household chores.

Private Caregiving

Many people turn to private caregivers to save money. Private caregivers are typically more experienced and work off of word of mouth referrals. Most people do not know or don't have the ability to do the proper background and vetting necessary to select a good caregiver. Good caregivers are very hard to find for most families. This can be a stressful situation and can be compounded with the fear of tax liabilities.

Referral Agencies

Referral Agencies (like San Luis Obispo Caregivers) recruit, background check, and interview caregivers for the client to hire their own private caregiver without the hassle and risk of doing this on your own. Referral agencies provide a significant price break for their clients while still performing all of the due diligence involved with selecting a good private caregiver. Independent Caregivers receive a 1099 Tax report at the end of the year which is given to independent contractors. For more information call (805) 748-2614.

Discharge To Do List

Discharge day arrives quickly! Family members and patients will usually get a 24 to 48 hour notice, but the actual date and time often changes. It is important to be prepared before you get the notice of discharge. The sooner you can begin the discussions about discharge the better.

These conversations should include

☐ Identifying Key Personnel and Their Roles

Ask if a discharge planner has been assigned to your case. If so, introduce yourself to them and begin asking them about the process, the team players and the questions outlined here.

☐ Assembling Your Support Team

If you have family or friends that can help, determine which ones can take a role or set of tasks such as transportation, filling prescriptions, etc.

☐ Discharge Timing

Based upon the diagnosis and treatment, discuss the estimated date or date range for discharge and what variables might affect it changing. Inquire about the discharge notification window and what time of day that discharge usually occurs.

☐ Discharge Criteria

- What are the guidelines that dictate when the patient will be discharged?
- Who has input into these criteria?
- How much is dictated by the insurance company or Medicare?
- What is the process if you disagree?
- What degree of discretion does your family have over the discharge decision?

☐ Transition to Home or Rehab Facility?

Does the patient have a choice between going directly home or to a rehabilitation facility? What are the pros and cons to each option and what are the costs? How much of this decision is the patients to make? What are your choices of rehabilitation facilities?

Rehabilitation Facility Options:

#1 _____

#2 _____

#3 _____

Pre-discharge Training

Prior to discharge, can family members and caregivers be trained in physical therapy exercises, transfer techniques and other important care techniques?

Pre-discharge Home Safety Assessment

The patient's capabilities have often changed drastically after a hospital stay. It is important that a professional assess the safety and accessibility of the patient's home and make recommendations before discharge. San Luis Obispo Home Care can help to assist you in this process.

Who will perform home safety assessment before discharge?

_____

Home Equipment

Medical Equipment like hospital bed, portable toilet, and other items should be ordered prior to discharge so they are in place upon arrival. Ask which equipment is covered by insurance or Medicare and which are not.

Suggested Equipment:

_____

_____

_____

_____

Actual Discharge and Transition to Home

The actual transition home can be the most stressful part of the process for everyone. The first 48 to 72 hours at home are often challenging. For example, sleep patterns may be dramatically off, loved ones are emotionally and physically exhausted and getting your family member settled in safely and comfortably takes time.

When preparing for the trip home, think about the following issues:

Transportation

What type of vehicle will you need for the ride home? Will you need non-emergency transport? Will more than one person be needed to assist?

Medications & Prescriptions

Seniors are highly sensitive to changes in medication and dosages. It's highly possible that medications have changed substantially by the attending physician during the hospital stay so be prepared to ask about prescriptions, fulfillment of medicines, and being able to leave with an ample supply of medications to bridge you until prescriptions are filled.

Training & Instructions

Make sure training and instructions for tending to wounds, exercise, rehabilitation and other recovery protocols are clear before you go home.

Nutrition & Sleep Patterns

Before going home, understand the patient's diet and sleep patterns. It's highly possible that the patient has been sleeping during the day and awake at night which presents significant challenges.

Ensuring Proper Care Coverage at Home

By law, facilities now have to make sure that elderly patients are not discharged without the proper care in place at home. Discuss your loved ones needs with the discharge planner and get guidance for coverage based upon your needs.

Coordination & Referrals for Services at Home

A major role of a discharge planner is to coordinate third party services to be delivered at home upon your return.

A few of these include:

Medicare Certified Home Health Agency

Most elderly patients obtain authorization to receive therapy (physical, occupational or speech) as well as nursing care at home through a state licensed home health agency. Your discharge planner should give you the names of at least three qualified agencies from which you can choose.

Medical Equipment

obtaining the proper equipment like hospital beds, oxygen or other necessary elements in place before you get home is important. Ask your discharge planner who will be coordinating this and if you can get it in place prior to or in parallel with discharge.

Home Care Agency

often considered the highest cost to getting care at home. May be partially covered by Long term Care Insurance. All home care companies should be licensed with the state of California. Go to the Department of Social Services page of the ca.gov website to understand the new regulations for home care agencies.

Independent Caregivers/Referral Agency

Many patients look to friends and families to refer them to a private caregiver in an effort to save money. The problem with that is the lack of background checks and due diligence performed which may result in a very bad selection. Referral Agencies like San Luis Obispo Caregivers carefully match caregivers and clients to maximizing the dollars you spend. All caregivers pass a 9 step quality assurance background screening process before they are eligible to receive a referral. Contact owner David Wood at 805-748-2614 for more information and a free in home consultation.

Follow-Up Medical Care & Appointments

If complications arise shortly after the return home, who do you call and what is their contact information? Have plans been made for any follow up visits to physicians to ensure continuity of care?

Our Doctor is: _____

I have set an appointment for Date: _____ **Time:** _____

Strategies to Keep You in Your Home

The goal for most patients coming out of the hospital is to recover at home and prevent a return trip to the hospital. Unfortunately, 1 in 5 of all Medicare patients will return to the hospital within 30 days for treatment related to their original admission. The good news is that you can have a positive impact on preventing a return to the hospital by putting the support structure in place before you arrive home.

Best Practices

Set Appointment with your Primary Care doctor

Visit should be set for 7 to 10 days after discharge. (High Risk)

Medication Management

A significant percentage of older adults are hospitalized due to medication complications. (High Risk)

Questions to ask

- o Are there new medications?
- o How long do you take them?
- o Are old medications still relevant?
- o Side effects to look for?
- o When are they taken, is it confusing?
- o Reorder procedure?
- o Where is the pharmacy?
- o Does insurance cover them all?

Home Safety Fall Risk

Since being hospitalized, the patient's physical abilities may have changed dramatically upon their return home. To stay safe, it's crucial that a patient can safely operate in their home environment with their new limitations. If you need a home safety checklist you can go to our website: www.slocaregivers.com. (High Risk)

Remember

- o Take it slow – pause when or if you stand up.
- o Install grab bars, ramps and proper lighting in your home
- o Watch out for cats and dogs – they can trip you!
- o Follow your doctors instruction – do your exercises
- o Have caregiver there to support you

Care Coverage

it is important to think through the various times of day that you will need care coverage. Below is a checklist of activities that need to be accomplished. The most challenging times of the day tend to be the mornings, late afternoons and early evenings when most of the activities related to personal care and meals take place. (High Risk)

Day to Day Care

Activities of Daily Living (ADL's), these activities are usually the most time consuming and risky form of care during the recovery process.

- [ ] Meals/Nutrition
- [ ] Transportation
- [ ] Medication Reminders
- [ ] Shopping/Errands
- [ ] Companionship
- [ ] Housekeeping/Linens
- [ ] Transportation to Medical Appointments
- [ ] Ambulation/Exercise/Rehab
- [ ] Recreation
- [ ] Bathing/Toileting/Dressing
- [ ] Grooming/Hygiene

Emotional & Social Support

Depression is a very real symptom after returning home and nobody likes to talk about it. Isolation from others can become an issue which negatively affects a patient's recovery. It's important that during the time of transportation that the person is not forgotten.

Physical Exercise and Rehabilitation

Exercise and rehabilitation is difficult even for us. Encourage and follow through with the programs established by their therapists. Realize that your loved ones need your support and encouragement to be successful. Caregivers can be very effective in this role.

Hydration

It is always important to have a balanced diet and proper hydration, but even more so when recovering from a hospital stay.

The New Normal

It is impossible to anticipate how recovery might go. We always want to hope for the best, but be prepared for the worst. We call this the "New Normal". The first 30 days after discharge is the most critical time to indicate whether the patient has a full recovery or will it result in multiple return visits to the hospital. Nationally 20% of Medicare patients return to the hospital or facility within 30 days and the number goes up to over 30% within 90 days.

Many families will try and manage caregiving on their own. This can lead to frustration, stress, exhaustion, illness and often injury. While many family members will start out with great intentions and eager to do their part, they quickly find that other parts of their life are affected by this role. More than 1 in 6 Americans working full time report assisting with the care of an elderly family member and claim that it significantly affects their work and personal life.

Hiring a caregiver can also be very expensive and is not affordable by everyone. For those that can afford it, it seems to be an easy choice to alleviate risks of returning to the hospital and overall keeping everyone healthy.

For more free information on the subject please go to

www.slocaregivers.com