



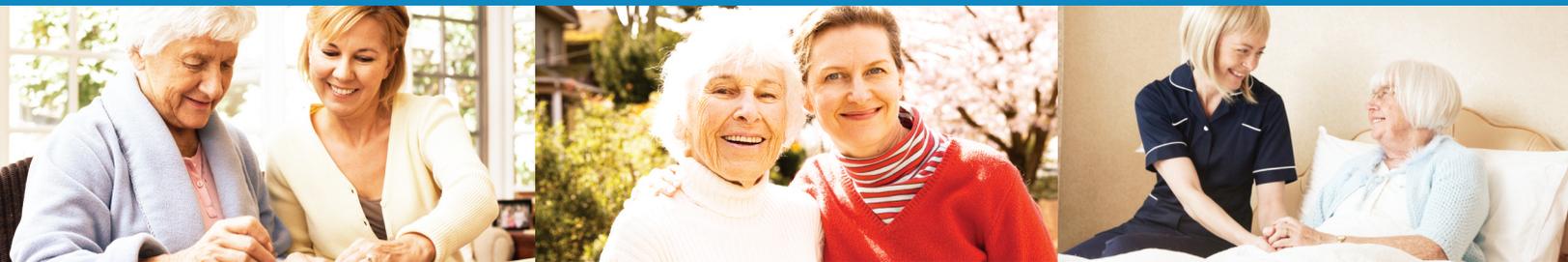
FROM
Hospital
TO HOME CARE



A Guide to Understanding the Hospital Discharge Process and Providing Care to Patients Post-Hospitalization

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FROM HOSPITAL TO HOME CARE:

A Guide to Understanding the Hospital Discharge Process and Providing Care to Patients Post-Hospitalization

At Home Care Assistance, we are committed to the wellbeing and safety of the clients we are privileged to serve. Many of our clients come to us following a hospitalization. They are referred to us by physicians, discharge planners, social workers and case managers; health and wellness professionals know that the transition from hospital to home can be a challenging one for patients and their families. One of the leading causes of hospital readmission or slow post-hospitalization recovery is the lack of proper support immediately following a hospital discharge. As the leading experts in post-hospitalization care, we developed this guide to provide an overview of the challenges and resources associated with each step in the transition from hospital to home. The guide will first describe what the discharge process entails and the key players involved. Next, it will provide a step-by-step summary on ensuring optimal care post-hospitalization. The transition out of the security of the hospital setting may seem daunting at first, but remember that you are not alone in this process. There is a team of individuals inside the hospital and in the greater care community to ensure that all of your needs are met. We hope our From Hospital to Home Care guide will equip you with the information you need to make the best decisions possible.

WHAT IS HOSPITAL DISCHARGE PLANNING?

The discharge planning team is responsible for coordinating a patient's transition out of the hospital and his or her post-hospitalization recovery.

As a hospital stay—be it for a planned surgery or unexpected admission—draws to a close, there are typically two options for post-hospitalization care. The hospital care team may recommend that the patient continue to heal and regain strength in a rehabilitation facility, or depending on a patient's needs and desires, the care team may recommend recovery and rehabilitation at home. Neither option is better or worse than the other—

while many people will respond positively to the rehabilitation center environment, others will find comfort in returning to more familiar surroundings. Being honest about one's preferences and abilities is the key to a well-informed decision.

WHO ARE THE KEY PLAYERS IN THE DISCHARGE PROCESS?

The Patient: The most important person in the discharge planning process is the patient. The care team will typically respect the patient's preferences during the discharge process. Recent studies have demonstrated that recovery at home is comparable to, and in some cases more favorable than recovery at a facility. However, every individual has his or her own preferences when it comes to discharge. This is why it is critical to establish open lines of communication as early as possible during the hospitalization. Clear communication allows the patient to voice personal desires and concerns and allows the discharge team and family members to share their thoughts and recommendations.

The Patient's Family Members and Caregivers: Family members and caregivers are a vital part of the discharge planning process because they are the ones who will help manage the patient's care in the home or post-hospitalization facility. They can provide valuable input to the discharge team that the patient may not have fully considered. For example, a patient may be steadfast in the desire to return home, but the patient's family may alert hospital staff that there is no one in the home strong enough to transfer the patient, who cannot yet walk independently. It often falls to the family to ensure that the best possible decisions are made for a successful recovery and for the patient's wellbeing.

The Discharge Planner: The discharge planner, usually a nurse or a social worker, coordinates a patient's discharge from the hospital and post-hospitalization care strategy. The discharge planner wears several hats. She has to consider cost effectiveness for the hospital while also considering the family's wishes and the wellbeing of the patient. To balance these priorities the discharge planner must maintain good relationships with post-hospitalization care providers such as rehabilitation hospitals, nursing facilities, hospices and home health companies.

The Nursing Team: Nurses who have taken care of the patient day in and day out are an extremely valuable resource during the discharge planning process. They are able to comment, for instance, on a patient's mental status, stamina, ability and willingness to

follow directions. They will also be able to provide valuable advice to the family based on their experience and their understanding of the patient's time at the hospital.

The Physician: The physician signs off on the final discharge plan and is responsible for prescribing medications which can have a direct bearing on the patient's comfort and mood. The physician's primary goal is the patient's physical and mental wellbeing.

The Social Worker: The social worker has three responsibilities: (1) to assess the patient for psychosocial factors that could impact discharge plans, (2) to help connect families with relevant community resources and (3) to provide emotional support and guidance to patients and their families. Social workers can be a tremendous resource, especially if the patient has spent significant time in the hospital or is at risk of depression or other emotional issues during the transition home.

The Skilled Therapists (OT/PT/ST): Occupational therapists, physical therapists and speech therapists can play a role in the discharge planning process by communicating the patient's capabilities and deficits to the discharge planner. These skilled therapists will also play an important role in the post-hospitalization care process.

Geriatric Care Managers: Geriatric Care Managers are trained professionals who advocate on behalf of the patient and the family. They coordinate services for the patient, acting as liaison between the different agencies that provide services to post-hospitalization patients. Many Geriatric Care Managers maintain independent practices in the community and are hired by the patient's family. Geriatric Care Managers usually conduct a comprehensive assessment of the patient, noting physical, social and emotional strengths and weaknesses, in order to develop a care plan and coordinate care providers for the patient.

Home Care Agencies: Home care agencies provide non-medical care via expertly trained caregivers. These caregivers assist with activities of daily living (ADLs), such as bathing, grooming, dressing, light housekeeping and meal preparation*. Home care is often an integral component of the post-hospitalization recovery process, especially during the initial weeks after discharge when the patient still requires some level of regular physical assistance.

*These activities, though non-medical, are often extremely challenging for post-hospitalization patients.

Home Health Care Agencies: Home health care agencies are covered by Medicare to help patients who need the intermittent skilled services of a nurse, physical therapist, occupational therapist or speech therapist. Home Health agencies typically provide intermittent short-term services, on the order of one or two hours per day for 30 days or less.

Hospice: For terminally ill patients, hospice can be a valuable resource in the discharge planning process. Hospice care focuses on the patient's comfort and quality of life through symptom management rather than aggressive medical treatment, which can leave the patient physically and emotionally drained. Many hospitals have their own hospice programs and there are also valuable services in the community.

WHERE DOES THE DISCHARGED PATIENT GO?

While many patients want to immediately return home following discharge, this is not always a viable option. As a stay in the hospital draws to a close, the patient will typically be presented with two options for the recovery process.

Option A: Rehab or Skilled Nursing Facility

After a patient has undergone a procedure in the hospital, such as a hip replacement, or been admitted for an unexpected medical event, such as a stroke, a care manager will typically recommend 30 days of rehabilitation at a facility. Ultimately, the patient and the patient's loved ones can decide if this is a good option.

Advantages:

A stay in a rehabilitation center is typically covered by Medicare. These benefits will frequently cover three to four hours per day of active rehabilitation—whether that is physical therapy, occupational therapy, or speech therapy. Additionally, each rehab facility is overseen by a Registered Nurse and every patient is assisted by Certified Nursing Assistants. For skilled nursing facilities, the Medicare benefit pays for several weeks of care so long as the patient demonstrates progress in therapy, or that the condition is unstable enough to require around the clock skilled nursing.

Disadvantages:

Any extended stay in a medical facility can increase the risk of infection or illness, simply due to the proximity to patients recovering from illness. Likewise, for some people, further stay in a hospital setting can lead to depression or a feeling of being institutionalized. By nature, facility care is very structured and outside of pre-set therapy times, patients are often bedbound. In addition, care staff are often spread across many patients, limiting the amount of individual attention. In fact, for many procedures, including hip replacement, a carefully planned discharge to the home is a more effective recovery solution. Further, though Medicare typically covers some level of post-hospitalization rehabilitation, coverage is not guaranteed and subject to regular evaluations of the patient's condition.

Option B: Recovery at Home

Patients who prefer the comfort of more familiar surroundings also have the option of recovering and undergoing the rehabilitation process in the home.

Advantages:

Working with a personal caregiver provides the individual customized attention, ranging from a few hours a day to around-the-clock care 24 hours a day. Likewise, visiting therapists can cater to the specific recovery needs of a client at home. For example, to practice walking stairs, a therapist can utilize the exact staircase the patient will eventually need to climb. This level of customization is not available in a rehab facility*. For most adults transitioning out of the hospital setting, home care is the solution that offers the greatest security and happiness for the client and the most peace of mind to his or her family.

Disadvantages:

While short-term home health agency costs may be covered by Medicare, private home care is typically an out of pocket expense. The caregiver can provide dedicated one-on-one support at a level beyond the services of a rehabilitation facility. Caregivers are dedicated to their clients full-time to support their range of needs from meal preparation, transportation and housekeeping to more complex needs associated with chronic conditions. Home care can be an integral part of patient outcomes and quality of life following a hospitalization. Consider speaking with a Home Care Assistance care manager about the Transition Home™ package and a personalized care plan for your specific situation.

* In addition, the patient benefits psychologically from the comfort of home and has a smoother transition back to a familiar routine and lifestyle. Further, patients recovering at home can benefit from full-time, 24-hour services from a caregiver; the level of care is far more personalized than at a nursing facility and families enjoy peace of mind knowing a trained professional is always at home.

PREPARING FOR LONG-TERM RECOVERY

After the rehabilitation process ends, the goal is to ensure that the patient has all the resources necessary to continue healing and recovering.

Keep in mind that the majority of patients will need some form of support as they transition back home from the hospital. Below we have outlined some of the steps patients should take as they prepare for a longer recovery.

Choosing Home Care: Regardless of which setting a patient goes to following discharge from the hospital, caregiver services from a home care provider can be an extremely valuable source of support. While the name home care may lead one to believe that caregivers only come into patients' homes, in fact home care agencies quite often send caregivers to care for patients in hospital, rehabilitation, skilled nursing, assisted living and hospice settings.

Appendix A and B at the end of this document are valuable tools to assist patients and their loved ones in choosing an appropriate home care agency and caregiver(s).

Getting The Necessary Supplies: Before a patient ends a rehabilitation program is discharged, the discharge planner at the hospital should produce a list of supplies the patient will need to recover at home. These supplies can include wheelchairs, walkers and hospital beds, and can include more complicated equipment such as oxygen tanks and concentrators, if needed. These supplies are typically paid for by Medicare.

If a patient chooses a home care service to aid in his or her recovery, the home care agency will help coordinate a safe home recovery environment. Prior to discharge, a care manager from the home care agency can meet with the patient and the family to survey the home and provide recommended safety improvements. These typically include customized adaptations such as grab bars in the shower, raised toilet seats, and shower benches.

The first days at home will be an adjustment for the newly discharged individual no matter how carefully everyone has planned prior to discharge. It typically takes 72 hours for discharged patients to begin to feel comfortable at home again. In the meantime, the individual may feel fatigued. Being in a hospital or rehab setting can take a high toll on an

individual's physical, psychological and mental state and this can contribute to weakness or lethargy. When an individual is recovering, a typical day should revolve around five activities:

- **meals/snacks**
- **medications**
- **rest**
- **bathing**
- **therapy**

Home care can greatly facilitate the development and maintenance of the post-hospitalization routine. Caregivers can help patients with regular meal times, medication reminders, therapy schedules, follow-up medical appointments and more. In addition, the caregiver provides constant monitoring and support that is critical to patients with mobility or dexterity issues. Finally, the caregiver can allow the patient to focus on rest and recovery by taking on household and other daily responsibilities.

The home care provider should work closely with the patient, the family and the discharge team to develop a regular routine. In addition, the provider will typically provide care management to ensure that the patient is following the routine and that any issues are regularly communicated to the family and care team.

Eventually, this routine will become second nature. Until then, remember:

- Resting helps the body recover faster. Naps should range from 1 ½ to 3 hours to ensure a full REM cycle.
- After a week at home, the patient should set scalable and measurable goals. For example, by the end of the next week, the patient may aim to walk independently to the bathroom. Setting goals and working toward them is not only important for physical recovery, but for mental recovery as well.

SIX STEPS TO RECOVERY

As you plan for your recovery, keep in mind that it can be a gradual process. Recovery typically follows a six-step progression and can require anywhere from a few weeks to months, depending on the cause of your hospitalization. As you progress through these steps, you should constantly evaluate your own strength and confidence. You should never move on to the next step until you are ready.

- 1. Dependence.** When you first return home after your hospitalization, your primary goals should be rest and recovery. Your caregiver is there to support you and can handle your laundry, meal preparation, errands and any other household tasks. Focus your energy on recommended therapy exercises, activities and caloric intake. Don't be concerned if you need more help than you expected.
- 2. Mild Independence.** When you feel stronger, you should ask your caregiver to cut back on hands-on care whenever possible. Identify tasks that you can now manage independently, such as eating or walking down the stairs, and slowly wean yourself off of care in these areas. Never compromise your safety; ask your caregiver to step in if you feel uncomfortable.
- 3. Supervised Independence.** Over time, you should gradually increase your independence. Your caregiver should be there to assist if needed, but the caregiver's primary role should be supervision and safety monitoring rather than direct physical assistance. Try to perform the activities of daily living – bathing, dressing, grooming, eating, walking – as independently as possible.
- 4. Supported Independence.** Once you are comfortable with the activities of daily living, you can incorporate chores and other housework into your routine. Try a trip to the grocery store or the pharmacy accompanied by your caregiver, or join in to prepare a meal together. Though these steps may seem minor and incremental, they are important touchstones in your path toward a full recovery.



- 5. Semi-Supported Independence.** In this phase, you should try to take responsibility for day-to-day tasks and return to your pre-hospitalization routine. Just remember, your caregiver is there to assist you if you need help, but try not to take advantage of that assistance unless you really need it. Some activities may be more difficult following a hospitalization, regardless of the progress in your recovery.
- 6. Full Independence.** If you feel you can safely return to all of your regular activities without the support of a caregiver, you may consider reducing your care. Evaluate your own comfort level, especially if you are living alone or with a spouse who also requires some level of care. Remember that full independence is a long-term goal and should not be prioritized ahead of your safety.

APPENDIX A: DISCHARGE PLANNING TOOL

- Do you have friends or family members who will be helping you after your discharge or who you want involved in the discharge planning process?

Name(s): _____

Contact Information: _____

- Do you have a strong preference regarding where you will go after you discharged? Please make notes below on where and why.

- There are a number of common concerns hospitalized individuals have about being discharged, please put a tic next the ones that apply so that you can remember to speak to the discharge planner about them:

___ I have pets

___ I need help being transferred and I weigh _____ lbs.

___ I have work/school obligations

___ I have parenting/family caregiving obligations

___ I will need medical support (e.g. injections, wound care)

___ I do not think I can do the following alone:

___ Cooking, shopping, driving, paying bills

___ Bathing, dressing, using the restroom

___ Transferring, moving

___ Physical/speech therapy exercises

- These are my medications/vitamins/supplements (include dosage) that I was taking before I was admitted.

(Ask medical team if you should make any modifications/discontinue any medications after you are discharged)

APPENDIX B: AGENCY CHECKLIST

How does your Agency Choose Its Caregivers?

- What is the process for screening your caregivers? Do you complete a background check (criminal, driving, work permit status and past references)?
- Do you have a minimum for years of caregiving experience for applicants?
- What is the ratio of the applicants you hire to the applicants you interview?
- What is the training procedure for newly hired caregivers? What types of topics are covered?
- Do you offer continuing education training for your caregivers?

What Are Your Agency's Staffing and Scheduling Procedures?

- How do you match caregivers to clients? Do you guarantee a personality match and offer caregiver interviews? What happens if a senior wants a different caregiver?
- Is it typical to expect the same caregiver each time or do you rotate caregivers?
- What steps do you take to ensure reliable staffing?
- What happens in the event that a caregiver is unavailable or calls in sick?

What Is the Agency's Legal Responsibility?

- Are your caregivers screened, bonded and insured? Do you employ your caregivers and take care of taxes, withholding and workers' compensation?
- What protections are there against theft?
- What client services, caregiver services and confidentiality forms are used and can you describe the main points of each?

What Makes Your Agency Stand Out?

- What unique programs/trainings/materials does your agency offer its caregivers, staff, and clients compared with other agencies?
- What types of payments do you accept and what are your billing procedures (is there a contact? Cancellation fee?)
- Is the care manager available on-call 24/7? Does he/she perform regular quality assurance visits?
- Is the company a recognized leader in the senior care industry with published books on senior wellness and caregiving?

APPENDIX C: CAREGIVER INTERVIEW GUIDE

Employment History

- How long have you been a caregiver?
- What is your previous employment history?
- Were you ever dismissed from a position? Why?
- Do you have any credentials, training, education history, awards you can share with me?

Caregiving Background

- Why are you a caregiver?
- What is the most rewarding aspect of your job?
- What is the most frustrating aspect of your job?
- What special skills do you have that you think will be useful for this case?
- Are you comfortable with providing the following tasks: [fill in based on your needs, e.g. driving, cooking, cleaning]?

Personality Matching

- How do you respond to stressful situations?
- Would you consider yourself a patient individual?
- Do you like to engage in conversation or do you prefer quiet time?
- Do you have any hobbies or interests?
- My [loved one] enjoys [activity, food, hobby], is this something you could help him/her continue?

ABOUT HOME CARE ASSISTANCE

Home Care Assistance was founded in 2002 by Certified Care Managers and PhD Clinical Psychologists. Our mission has always been to offer the highest standard of care for our clients and we are proud to have made a difference in the lives of thousands of seniors and their families in the last decade. Our care managers are on call 24 hours a day for client needs and our caregivers are professionally trained and personally committed.

At Home Care Assistance, we train all of our caregivers and staff in the Balanced Care Method™, our proprietary model of care based on studies of extraordinarily long-lived elders in the Okinawa region of Japan. Okinawa has the greatest concentration of centenarians in the world and among the lowest levels of cognitive impairment in the elderly population. The Balanced Care Method seeks to capture some of the lifestyle factors that lead to extended longevity and improved quality of life, including a healthy diet, regular physical activity, sharp minds, social ties, calmness and purpose. By focusing on seniors' mental and physical wellness, our caregivers extend and enhance the lives of our clients.

Our Services – We are proud of our reputation for high-caliber caregivers. Our caregivers take a holistic approach to our clients by encouraging independence and engaging them in physical, mental and social activities. Our caregivers help with meal preparation, personal hygiene, bathing, medication reminders, transportation and more on both an hourly and live-in basis.

Live-In Specialists – Our caregivers are specifically trained in around-the-clock care. Clients and their families have peace of mind with caregivers who monitor safety, attend to any immediate or daily needs and provide companionship. Live-In care is a cost-effective option for seniors who need an around the clock presence.

We Are Available 24/7 – We don't rely on voicemail, even during evenings and weekends, so you can always be comfortable that someone is here to help.

Our Caregivers – We only hire one out of every twenty five caregiver applicants. All caregivers must have at least two years of senior care experience. We check references, criminal backgrounds, driving records and work authorization documentation. Finally, we administer our exclusive Caregiver Personality Screening developed by our on-staff

PhD psychologists which verifies honesty, kindness and conscientiousness. Once hired, our caregivers attend our exclusive Balanced Care Method™ training, learning to provide moderation and variety to our clients in the areas of nutrition, physical exercise, mental stimulation and sociability.

Flat Rate and No Long-Term Contract – We have a flat rate fee structure, which means that as the level of need increases, our rates do not. There are no hidden fees for last-minute, short-term or weekend care. We don't require long-term contracts or commitments, so clients stay with us only as long as they are 100% satisfied.

Our Network – We're honored to be Preferred Providers for professionals in both the medical and senior communities. We are the trusted provider of home care services to the clients of care managers, assisted living and nursing communities, hospitals and senior centers throughout the area.

For more information or for a free copy of our book, *From Hospital to Home Care: A Step by Step Guide to Providing Care to Patients Post Hospitalization*, contact your local Home Care Assistance at 1-866-4-LiveIn or www.HomeCareAssistance.com. You can also find additional information at www.HospitaltoHomeCare.com.

Our Mission:

Our mission at Home Care Assistance is to change the way the world ages. We provide older adults with quality care that enables them to live happier, healthier lives at home. Our services are distinguished by the caliber of our caregivers, the responsiveness of our staff and our expertise in Live-In care. We embrace a positive, balanced approach to aging centered on the evolving needs of older adults.

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