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Family Caregivers & Your Case Management Program: CMS Proposed Discharge Planning Rules

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FACULTY

Toni G. Cesta, Ph.D., RN, FAAN is a founding partner of Case Management Concepts, LLC, a consulting company that assists institutions in designing, implementing and evaluating case management models, new documentation systems, and other strategies for improving care and reducing cost. Dr. Cesta is the author of eight books, a frequently sought-after speaker, lecturer and consultant and is considered one of the primary thought leaders in the field of case management. Dr. Cesta also writes a monthly column called "Case Management Insider" in AHC Media's Hospital Case Management newsletter in which she shares insights and information on current issues and trends in case management.

Dr. Cesta has been active in the research and development of case management for over 20 years. Her research in case management has included two funded studies measuring the effects of a case management model on congestive heart failure and fractured hip patient populations, with measures of patient satisfaction, quality of life, and short and long term clinical perceptions and outcomes.

Dr. Cesta has presented topics on case management at national and international conferences and workshops. She has published extensively including the fourth edition of her book, "Nursing Case Management: From Essentials to Advanced Practice Applications," the second edition of "The Case Manager's Survival Guide: Winning Strategies for Clinical Practice" which won the AJN Book of the Year award, "Survival Strategies for Nurses in Managed Care", and her newest book- "Core Skills for Hospital Case Managers".

Bev Cunningham, RN, MS is a founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a fellow with the Advisory Board.

Bev is also former Vice President Resource Management at Medical City Dallas Hospital where she had responsibility for Case Management, Health Information Management, Patient Access, Physician Integration and Solid Organ Transplant. Prior to her position as Vice President, Bev served as Regional Director of Clinical Effectiveness for Mercy Health Partners, Toledo, Ohio. In this role she directed the Case Management, Quality Management, and Pre-Authorization Departments. She also served eight years as a consultant, assisting hospitals in implementing, evaluating and improving their case management programs. As a Clinical Assistant Professor for the Master of Nursing Program at the University of Oklahoma, she coached students in their clinical practicums. Bev continues to mentor students in a Master's of Healthcare Administration program.

Bev is a well-known speaker in the Case Management field. Her publications include a chapter CMSA's Core Curriculum for Case Management Certification and most recently, co-author of the book, Core Skills for Hospital Case Management. Bev has a BSN from Pittsburg State University, Pittsburg, Kansas and a Master of Science, Nursing Major, from the University of Oklahoma.

Objectives

- Describe the new CMS Conditions of Participations related to family caregivers.
- Review tools and techniques for assessing the family caregivers' readiness to care for their loved one in the home environment.
- Explore strategies for supporting family caregivers in the daily care of their family member.
- Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate case management protocols and penalties.

WHO ARE FAMILY CAREGIVERS?

- Those who care for ill or frail family members or friends
- Can take place in any setting
  - Home
  - Hospital
  - Rehab unit
  - Long-term nursing home

A PERSON IS A CAREGIVER IF THEY

- Take care of someone who has a chronic illness or disease
- Manage medications or talk to doctors and nurse's on someone's behalf
- Help bathe or dress someone who is frail or disabled
- Take care of household chores, meals or bills for someone who cannot do these things alone

FAMILY CAREGIVERS AND HEALTH CARE PROFESSIONALS

- Must work together
- Times of care transition (change in care setting) are particularly important
- Communication is key!

WHAT CAREGIVERS NEED

- A basic understanding of how things are expected to work in the new setting
- A chance to ask questions when they are ready to ask them
- Guides and materials
- Acknowledgement that they are a family caregiver!

THE CAREGIVER'S EXPERIENCE

May be

- Following a crisis
  - Hip fracture
  - Stroke
  - Accident such as a fall
- A slow process or gradual decline

DO THEY KNOW THEY ARE A FAMILY CAREGIVER??

- In today's complicated healthcare environment, "taking care" goes far beyond what any family member had to do in the past
- I'm not a caregiver – i'm a daughter, son, partner or wife

IT IS IMPORTANT THAT THEY SEE THEMSELVES AS A FAMILY CAREGIVER

- So that the person can act on their rights and authority
  - The right to get information about their family member's condition
  - The right to be involved in decision making about care
  - To be an essential partner on the health care team and be educated in how to provide care

- Find support services that they might otherwise miss
- In some states, being a family caregiver can protect the person from job discrimination

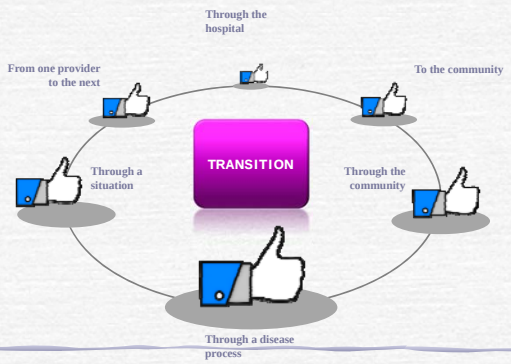
WHEN DOES CAREGIVING START

- Not the event itself but what happens after the event
- Health care professionals may assume that the caregiver is willing and able!

SURPRISE!

- The hospital discharge planner assumes that they will provide extensive care needs in the home
- The nurse tells them that their family member will be unable to feed themselves after a stroke
- Close family members that had been counted on are unable or unwilling to help

THE WHY OF TRANSITION PLANNING



DISCHARGE PLANNING IS A PROCESS-NOT AN EVENT

Patients and families may say: "Sometimes it seems as though discharge from the hospital happens all at once, and in a hurry."

But discharge planning is a process, not a single event.

As a result of that process, the discharge plan may be to send your relative to her own home or someone else's, a rehabilitation facility, a nursing home, or some other place outside the hospital. Discharge from a hospital does not mean that your relative is fully recovered. It simply means that a physician has determined that her condition is stable and that she does not need hospital-level care. If you disagree, you can appeal the decision.

From "A Family Caregiver's Guide to Hospital Discharge Planning"
www.caregiving.org

IT'S ALL ABOUT TRANSITIONS. . . . . .

- And effective transitions are the core business of hospitals—and a core responsibility of the case management department

DISCHARGE PLANNING EVALUATION (ADMISSION ASSESSMENT) STANDARD

- The hospital must provide a discharge planning evaluation to the patients, to other patients upon their request, the request of another person acting on their behalf, or the physician.
- The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and the availability of those services.
- The evaluation must include an evaluation of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

CATEGORIES TO BE INCLUDED IN THE EVALUATION

- Patient information
- Admission information
- Financial information
- Spoken language(s)
- Source of admission
- Significant prior medical history
- Mental status prior to admission

- Ability to make needs known
- Living arrangements
- Activities of daily living
- Prior resource use
- Primary care provider
- Social work triggers
- Home care triggers

SOCIAL WORK TRIGGERS

- Abuse – Domestic violence
- Abuse and/or neglect of a child
- Abuse and/or neglect of elder / Adult
- Abuse – sexual assault
- Adjustment to illness/ Difficulty coping
- Behavioral management problems
- Crime victim
- Cultural and/or language issues
- Drug abuse
- Ethical concerns
- ETOH abuse
- Family concerns and/or conflicts
- Guardianship
- Homeless requesting intervention
- Hospice placement
- Inadequate social support
- Inadequate financial support
- Long term care placement
- Major illness causing lifestyle change
- Multi-system trauma
- Name of patient unknown
- Non-compliance issues
- Poor prognosis
- Shelter placement
- Uninsured
- Undocumented
- Other

HOME CARE TRIGGERS

- Patients requiring assessments/education relating to:
- New diagnosis
- **New medications or change in medications**
- Change in patient's physical environment and/or new assistive device.
- Patients with unstable disease process; cardio/pulmonary, diabetes, neurological, neuromuscular, metabolic, cerebrovascular, cardiovascular, renal, cancer, pediatric/including asthma, premature infants, psychiatric
- Patients with open wounds, VAC wound care, pressure ulcers
- Patients with ostomies, trachs, feeding tubes
- Patients with drainage tubes and catheters
- Patients requiring I.V. and injectable drug therapies
- Patients with recent change in functional status including but not limited to; falls, paralysis, fractures, amputation or other physical impairment, change in custodial needs, ortho, neuro and or deconditioned diagnosis
- Patients with pain control management
- Patients with end stage disease and palliative care needs
- Patients with new oxygen and/or nebulizer treatments
- Patients receiving any type of home care services, i.e., CHHA, LTHHCP, PCA, private care, at time of hospital admission
- **Patients re-hospitalized within 60 days and/or known history of repeated hospital readmissions.**

INFLUENCES ON THE PATIENT'S TRANSITION: Patient/ Family

- Agreement with plan – CMS requirement!
- Perception of word "discharge"
- Timeliness in decisions
- Decision making process, including end of life decisions
- Family dynamics
- Geography
- Family types*
  - The Ghost; Difficult to track down and evasive in making decisions
  - The Sitter: Frequently makes visits to hospital, may have difficulty making decisions
  - The Peacock: Doesn't visit often, but makes big deal when involved
  - The White Knight: Present often, acts aggressively toward staff

From Brazelton and Bellamy presentation, NICM Conference 2004

IF THE FIRST TRANSITION

- Is from hospital to home
- An assessment of the family caregiver is important

IN FACT, THE FAMILY CAREGIVER IS AN IMPORTANT ASPECT OF THE CMS PROPOSED DISCHARGE PLANNING RULES

PROPOSED RULES TO CHANGE THE DISCHARGE PLANNING CONDITION OF PARTICIPATION

(Hit control f and type caregiver to see the vast number of times the word caregiver is used in this proposed rule)

ATTACHMENT 1

CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- November 3, 2015
- Comments accepted until January 3, 2016
- Estimated final rule first expected in February
- Now expected later in 2016

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CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Expanded which patients require a discharge plan before leaving the hospital
  - Patients discharged from critical access hospitals, long-term acute care hospitals, inpatient rehab hospitals
  - Observation service patients, ED patients, day surgery patients, patients receiving procedures and require anesthesia or sedation
- Plan must be started within 24 hours of admission
- Collaboration with community service providers is stressed as a need

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CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES: CAREGIVER

- Require that the patient's discharge plan address patient's goals of care and treatment preferences
- During discharge planning process, CMS would expect that appropriate medical staff would discuss patient's post-acute care goals and treatment preferences with patient, patient's family or their caregiver/support persons (or both) and subsequently document these goals and preferences in the medical record
- CMS expects these documented goals and treatment preferences to be taken into account throughout entire discharge planning process

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CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES: CAREGIVER

- Expect that hospital would be available to discuss and answer patients and caregiver's questions about post-discharge options and needs
- Expect that hospitals not make decisions on post acute care services on behalf of patients and their families and caregivers and instead focus on person-centered care to increase patient participation in post-discharge care decision making (Person-centered care focuses on the patient as the locus of control, supported in making their own choices and having control over their daily lives)

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CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES: CAREGIVER

- Expect discharge instructions be carefully designed to be easily understood by the patient or the patient's caregiver/support person (or both)
- As a best practice, hospitals should confirm patient or patient's caregiver/support person's (or both) understanding of the discharge instructions
- CMS believes patients or caregivers (or both) should be informed, in advance of hospital discharge, of anticipated need for filling outpatient (discharge) prescriptions, and have a plan on how they will obtain those medications

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CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Quality measures of post-acute care providers should be provided to patients and caregivers
  - CMS recommends use of Nursing Home Compare
  - CMS recommends use of Home Health Compare
  - These are to be used until quality measures in the IMPACT Act are available
- Patient information should be shared with next level of care providers
- Practitioner responsible for patient's care must be involved in discharge planning and participate in documentation of the plan

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CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Patients who are discharged home should have a copy of their discharge summary sent within 48 hours to the physician responsible for follow up care
- Pending lab results are to be sent to this same physician within 24 hours
- Critical access hospitals and home health agencies will have a new set of Conditions of Participation
- Discharge planning process must be written and approved by the hospital board (both initially and then routinely)

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CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Patient or patient caregiver capability and availability must be considered
- Availability and access to non-healthcare services must be considered—includes home and physical environment modifications, including assistive technologies, transportation services, meal services or household services (or both), including housing for homeless patients
- Discharge plan must address patient's goals of care and treatment preferences with documentation of such

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CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Discharge planning process must be assessed on a regular basis
  - Ongoing review or representative sample of discharge plans
  - Include patients readmitted within 30 days of discharge to ensure responsiveness to discharge needs
- Medication reconciliation required
- Patient to be made aware that they should assure a post acute care provider is in their network

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CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Appropriate staff must coordinate discharge plan
- Ongoing evaluation must identify any changes in discharge plan

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CMS ADDED ADVISORY BLUE BOXES TO SURVEYOR GUIDANCE

Attachment 2

- Published May 2013
- Advisory blue boxes are not to be used as citations during a survey, but these recommendations are to be optional for hospitals to use for discharge planning process "improvement"
- Advisory blue boxes became much of the content for the proposed discharge planning rule changes for the Condition of Participation: Discharge Planning

ADVISORY BLUE BOX RELATED TO FAMILY CAREGIVERS

For Information—Not Required/Not to be Cited

Providing a discharge planning tool to patients and their family or other support persons may help to reinforce the discharge plan. Use of the tools may encourage patients' participation in developing the plan as well as provide them an easy-to-follow guide to prepare them for a successful transition from the hospital. The tool should be given to patients on admission, reviewed throughout their, and updated prior to discharge.

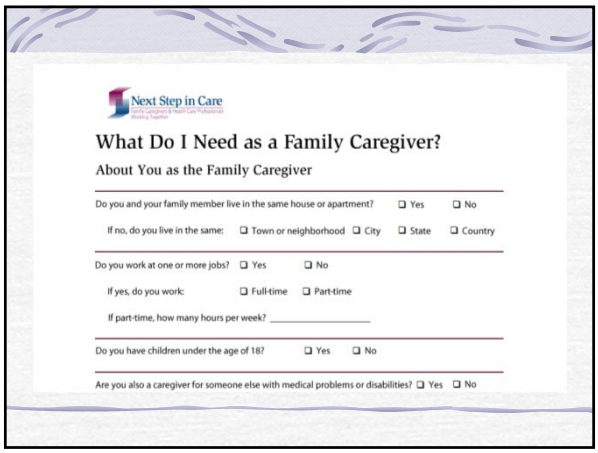
ADVISORY BLUE BOX RELATED TO FAMILY CAREGIVERS

Examples of available tools include:

- Medicare's "Your Discharge Planning Checklist" (available at http://www.medicare.gov/publications/pubs/pdf/11376.pdf)
- Agency for Healthcare, Research and Quality's (AHRQ) "Taking Care of Myself: A Guide for When I Leave the Hospital (available at http://ww.ahrq.gov/qual/goinghomeguide.pdf)
- Consumers Advancing Patient Safety (CAPS) "Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient Toolkit" (available at http://www.patientsafety.org/page/transtoolkit/)

ADVICE TO THE NEW FAMILY CAREGIVER

- Think before you act
  - Don't quit your job, move or sell your house
  - Set limits on what you can do
  - Let go of guilt



Next Step in Care

What Do I Need as a Family Caregiver?

About You as the Family Caregiver

Do you and your family member live in the same house or apartment? ❑ Yes ❑ No

If no, do you live in the same: ❑ Town or neighborhood ❑ City ❑ State ❑ Country

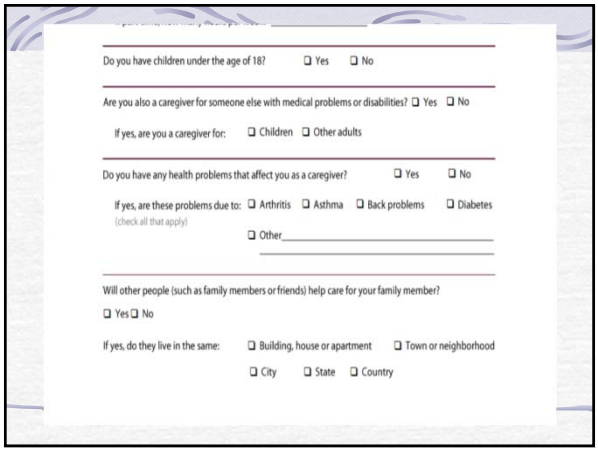
Do you work at one or more jobs? ❑ Yes ❑ No

If yes, do you work: ❑ Full-time ❑ Part-time

If part-time, how many hours per week? _____

Do you have children under the age of 18? ❑ Yes ❑ No

Are you also a caregiver for someone else with medical problems or disabilities? ❑ Yes ❑ No



Do you have children under the age of 18? ❑ Yes ❑ No

Are you also a caregiver for someone else with medical problems or disabilities? ❑ Yes ❑ No

If yes, are you a caregiver for: ❑ Children ❑ Other adults

Do you have any health problems that affect you as a caregiver? ❑ Yes ❑ No

If yes, are these problems due to: ❑ Arthritis ❑ Asthma ❑ Back problems ❑ Diabetes
(check all that apply)

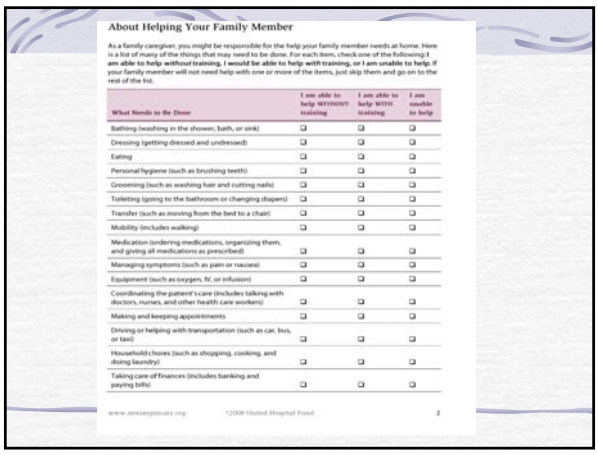
❑ Other_____

Will other people (such as family members or friends) help care for your family member?

❑ Yes ❑ No

If yes, do they live in the same: ❑ Building, house or apartment ❑ Town or neighborhood

❑ City ❑ State ❑ Country

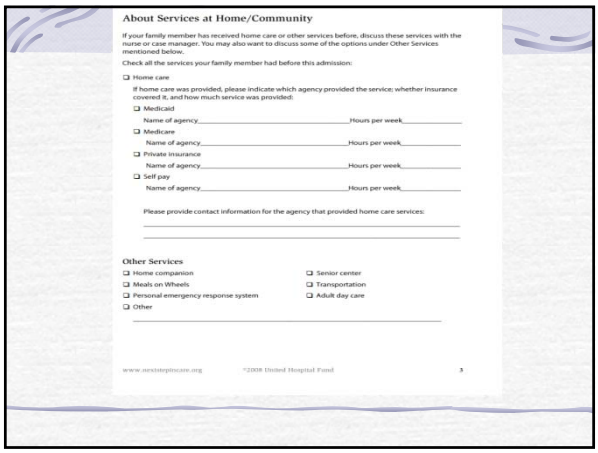


About Helping Your Family Member

As a family caregiver, you might be responsible for the help your family member needs at home. Here is a list of many of the things that may need to be done. For each item, check one of the following: **I am able to help without training, I would be able to help with training, or I am unable to help.** If your family member will not need help with one or more of the items, just skip them and go on to the rest of the list.

What Needs to Be Done	I am able to help WITHOUT training	I am able to help WITH training	I am unable to help
Bathing (washing in the shower, bath, or sink)	❑	❑	❑
Dressing (getting dressed and undressed)	❑	❑	❑
Eating	❑	❑	❑
Personal hygiene (such as brushing teeth)	❑	❑	❑
Grooming (such as washing hair and cutting nails)	❑	❑	❑
Toileting (going to the bathroom or changing diapers)	❑	❑	❑
Transfer (such as moving from the bed to a chair)	❑	❑	❑
Mobility (includes walking)	❑	❑	❑
Medication (ordering medications, organizing them, and giving all medications as prescribed)	❑	❑	❑
Managing symptoms (such as pain or nausea)	❑	❑	❑
Equipment (such as oxygen, IV, or infusion)	❑	❑	❑
Coordinating the patient's care (includes talking with doctors, nurses, and other health care workers)	❑	❑	❑
Making and keeping appointments	❑	❑	❑
Driving or helping with transportation (such as car, bus, or taxi)	❑	❑	❑
Household chores (such as shopping, cooking, and doing laundry)	❑	❑	❑
Taking care of finances (includes banking and paying bills)	❑	❑	❑

www.nextstepincare.org ©2008 United Hospital Fund 2



About Services at Home/Community

If your family member has received home care or other services before, discuss these services with the nurse or case manager. You may also want to discuss some of the options under Other Services mentioned below.

Check all the services your family member had before this admission:

❑ Home care

If home care was provided, please indicate which agency provided the service; whether insurance covered it, and how much service was provided:

❑ Medicaid
Name of agency_____Hours per week_____
❑ Medicare
Name of agency_____Hours per week_____
❑ Private insurance
Name of agency_____Hours per week_____
❑ Self pay
Name of agency_____Hours per week_____

Please provide contact information for the agency that provided home care services:

_____
_____

Other Services

❑ Home companion
❑ Meals on Wheels
❑ Personal emergency response system
❑ Other
❑ Senior center
❑ Transportation
❑ Adult day care

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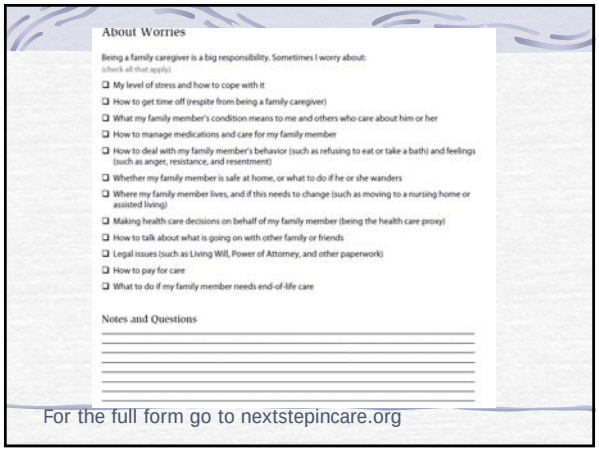


About Worries

Being a family caregiver is a big responsibility. Sometimes I worry about:
(check all that apply)

❑ My level of stress and how to cope with it
❑ How to get time off (respite from being a family caregiver)
❑ What my family member's condition means to me and others who care about him or her
❑ How to manage medications and care for my family member
❑ How to deal with my family member's behavior (such as refusing to eat or take a bath) and feelings (such as anger, resistance, and resentment)
❑ Whether my family member is safe at home, or what to do if he or she wanders
❑ Where my family member lives, and if this needs to change (such as moving to a nursing home or assisted living)
❑ Making health care decisions on behalf of my family member (being the health care proxy)
❑ How to talk about what is going on with other family or friends
❑ Legal issues (such as Living Will, Power of Attorney, and other paperwork)
❑ How to pay for care
❑ What to do if my family member needs end-of-life care

Notes and Questions

_____
_____
_____
_____
_____
_____
_____

For the full form go to nextstepincare.org

HANDLING TRANSITIONS

- Can be upsetting, disruptive, confusing
- Each transition brings:
  - New providers
  - New rules nad regulations
  - New financial requirements
  - New care plans

EDUCATING THE FAMILY CAREGIVER

- Learn all about the family member's condition
- Find out what your family member's insurance pays for – and what it doesn't pay for
- Review or create legal documents

- Have family member sign advance directive or health care proxy if they are able to do so
- Consider obtaining a durable power of attorney for financial affairs if the family member cannot pay bills or make financial decisions

- Consult with other family members regarding their feelings concerning
  - Medical care
  - Living arrangements
  - How the caregiving tasks can be divided
  - How to pay for what insurance doesn't cover

- Find out what is available in the community for the family caregiver and the patient
- Try to continue some of your previous activities
  - Try not to let care giving become overwhelming
- Think about how you will manage your job and caregiving
  - Family medical leave act

THE LONG HAUL

- Caregiving may not be a short time period – could go on for years instead of months
- Remind them to know their
  - Strengths
  - Limitations
  - And to be flexible

REMIND THEM TO TAKE TIMEOUT MOMENTS. THINGS CHANGE OVER TIME

- Family member's condition may get better or worse
- New complications may arise
- If the family member has memory problems, he or she may not be safe alone anymore
- A new hospitalization may mean new medications and new treatment plaNS

Name (Last) (First) (Middle)

Primary Address

City State Zip Code

Home Phone Work Phone Mobile Phone

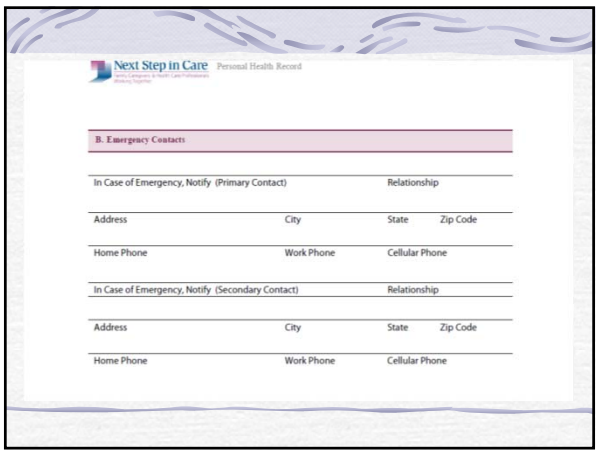
Date of Birth (M/D/YY) Sex: ❑ Male ❑ Female

Blood Type, if known Languages Spoken

Occupation (If Relevant) Company Phone

Company Name Company Fax

Company Address City State Zip Code



Next Step in Care Personal Health Record

C. Health Insurance Information

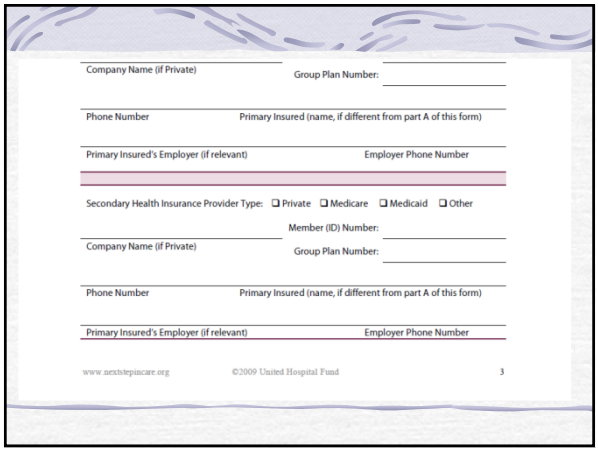
Primary Health Insurance Provider Type: ❑ Private ❑ Medicare ❑ Medicaid ❑ Other

Company Name (if Private) — Member (ID) Number: — Group Plan Number:

Phone Number — Primary Insured (name, if different from part A of this form)

Primary Insured's Employer (if relevant) — Employer Phone Number

Secondary Health Insurance Provider Type: ❑ Private ❑ Medicare ❑ Medicaid ❑ Other



Company Name (if Private) — Group Plan Number:

Phone Number — Primary Insured (name, if different from part A of this form)

Primary Insured's Employer (if relevant) — Employer Phone Number

Secondary Health Insurance Provider Type: ❑ Private ❑ Medicare ❑ Medicaid ❑ Other

Company Name (if Private) — Member (ID) Number: — Group Plan Number:

Phone Number — Primary Insured (name, if different from part A of this form)

Primary Insured's Employer (if relevant) — Employer Phone Number

Next Step in Care Personal Health Record

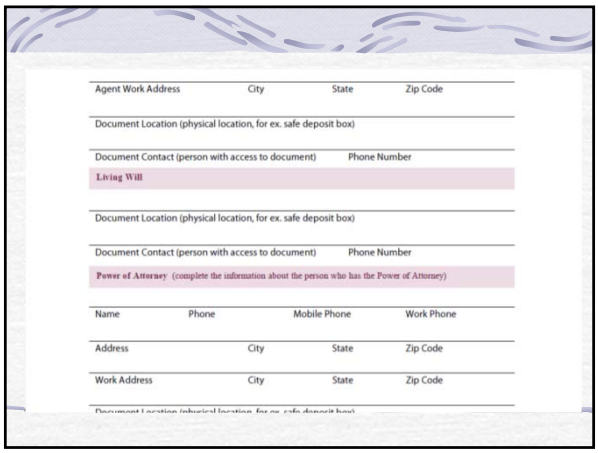
D. Advance Directives

(includes Health Care Proxy, Living Will and Power of Attorney)

Health Care Proxy *(complete the information about the person named as the agent on your family member's Health Care Proxy form)*

Name — Phone — Mobile Phone — Work Phone

Agent Address — City — State — Zip Code



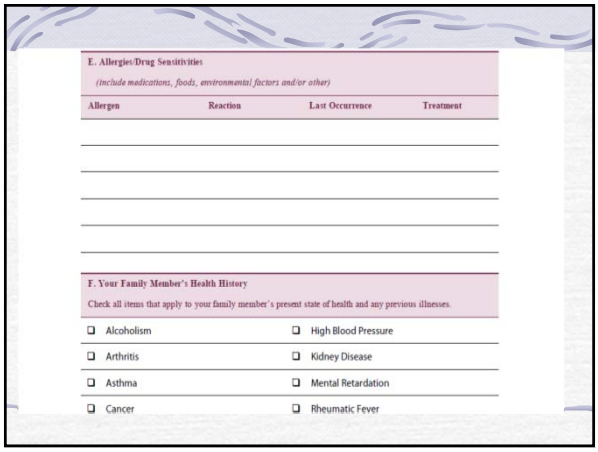
Agent Work Address	City	State	Zip Code
Document Location (physical location, for ex. safe deposit box)			
Document Contact (person with access to document)		Phone Number	

Living Will

Document Location (physical location, for ex. safe deposit box)			
Document Contact (person with access to document)		Phone Number	

Power of Attorney (complete the information about the person who has the Power of Attorney)

Name	Phone	Mobile Phone	Work Phone
Address	City	State	Zip Code
Work Address	City	State	Zip Code



E. Allergies/Drug Sensitivities

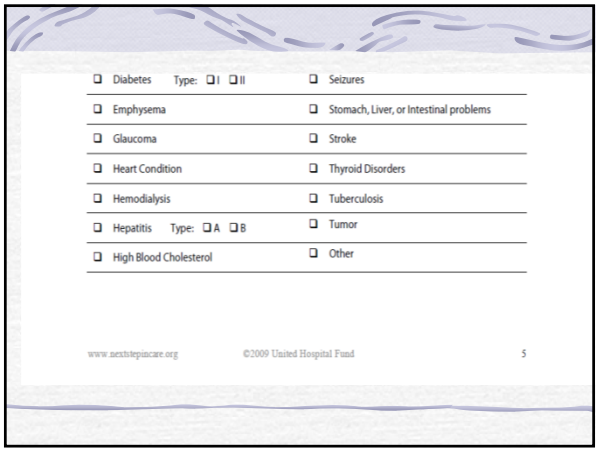
(Include medications, foods, environmental factors and/or other)

Allergen	Reaction	Last Occurrence	Treatment

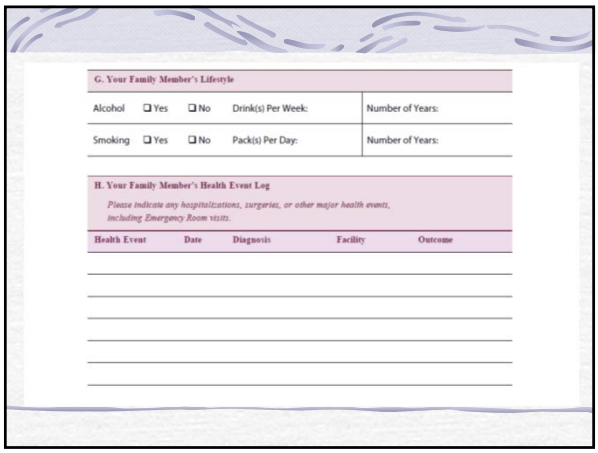
F. Your Family Member's Health History

Check all items that apply to your family member's present state of health and any previous illnesses.

❑ Alcoholism	❑ High Blood Pressure
❑ Arthritis	❑ Kidney Disease
❑ Asthma	❑ Mental Retardation
❑ Cancer	❑ Rheumatic Fever



❑ Diabetes Type: ❑ I ❑ II	❑ Seizures
❑ Emphysema	❑ Stomach, Liver, or Intestinal problems
❑ Glaucoma	❑ Stroke
❑ Heart Condition	❑ Thyroid Disorders
❑ Hemodialysis	❑ Tuberculosis
❑ Hepatitis Type: ❑ A ❑ B	❑ Tumor
❑ High Blood Cholesterol	❑ Other



G. Your Family Member's Lifestyle

Alcohol	❑ Yes	❑ No	Drink(s) Per Week:	Number of Years:
Smoking	❑ Yes	❑ No	Pack(s) Per Day:	Number of Years:

H. Your Family Member's Health Event Log

Please indicate any hospitalizations, surgeries, or other major health events, including Emergency Room visits.

Health Event	Date	Diagnosis	Facility	Outcome

NOT ALL READMISSIONS ARE AVOIDABLE – BUT SOME ARE!

- In-patient issues
  - Discharged too soon
  - Poor or inadequate discharge plan
  - No plan for follow-up care
- Out-patient issues
  - Patient does not have or does not keep md appointment
  - Medication compliance

CAREGIVERS AND PATIENTS

- Caregivers sometimes complain that they are not involved in discharge process details
- Proactively involve informal and formal family caregivers during hospitalization and at discharge

DISCHARGE INSTRUCTIONS

When did you last look at yours?

- Are they legible?
- Do they use too much medical jargon?

Most patients do not remember much detail about their discharge instructions, so written communication and community follow-up are very important!!!

MEDICATION MANAGEMENT

- Educate the family caregiver regarding medications:
  - Prescription meds – ordered by a doctor
  - Over-the-Counter (OTC) – Sold without a prescription
  - Herbal medications – vitamins, dietary supplements, and herbal teas sold at pharmacies, health food stores

HOW MEDS COME

- Pills or capsules
- Liquids
- Patches
- Medicated creams
- Inhalers
- Injectable solutions
- Chewable or dissolving agents
- Suppositories
- Ointments
- Eye drops
- Ear drops

MEDICATION MANAGEMENT

- Order prescriptions and pick up refills at pharmacy or mail order
- Read medication labels and follow all instructions
- Give the right medication at the right time and in the right amount

TEACH THEM ABOUT MEDS

- Types of side effects such as nausea and vomiting, confusion or dizziness
- Check labels for expiration or “use by” dates
- Make sure no one else takes the patient’s meds
- Keep all meds in a safe place

OTHER TOOLS FOR THE FAMILY CAREGIVER

- List of common abbreviations on presciptions
  - Sig – write
  - Bid – take med twice daily
  - Qid – take med four times daily
  - Q 3h – take med every three hours
  - Qd – take med every day
  - Prn – take med as needed
  - PO – take med by mouth only

MEDICATION RECONCILIATION

- Keep an up-to-date medication list
- Keep this list near by and easily obtained
- Bring this list each time you see a doctor or go to the hospital
- Discuss all the medications with your doctor including side effects or other problems to watch for

Common Medication Problems What You Can Do

Problems related to the name of the medication. The name of the medication you get from the pharmacy is not always the same as the name the doctor wrote in the prescription for a "brand" name while the pharmacy gave you the same medication in its "generic" name. This can happen when insurance will only pay for the generic form.

- Ask the doctor if the name on the prescription is brand or generic.
- Ask the doctor if it matters whether your family member takes the brand-name or generic version of this medication.

Problems reading the prescription.

You should compare the written prescription with the medication you get from the pharmacy.

- Tell the doctor or nurse if you cannot read what he or she writes in the prescription.
- Ask your doctor to write this more clearly.

Problems getting prescriptions filled.

- Insurance may not pay for certain prescriptions.
- The pharmacy may not accept your family member's insurance as payment.
- The pharmacy may not have the medication.
- Talk with your family member's doctor or nurse. He or she may help you figure out a solution.
- Call the insurance company to see if they can help you.

Problems hearing what the doctor, nurse, or pharmacist is saying. This can happen when the other person is rushed or you are talking in a noisy place.

- Tell people you cannot hear, and ask them to speak louder.
- Ask people to write what they are saying so you can read it later.
- Make sure you understand everything you need before leaving the doctor, nurse, or pharmacist. It will be more difficult to get answers later.

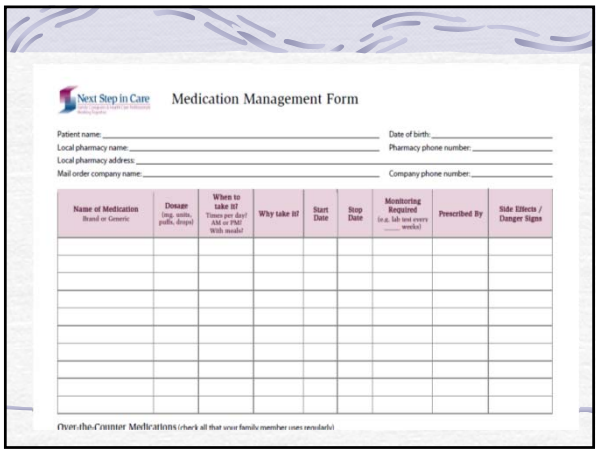
Problems remembering to take medications.

It is easy to forget to take medications on time, even more so when your family member needs to take two or more medications.

- Use special pill boxes that have sections to put pills for each meal and for bedtime. Some boxes even beep or make another noise when it is time to take Medication.
- Ask about special bottles with caps that count how many times the bottle has been opened (a way of knowing how many pills have been taken).

Problems opening pill bottles or giving medications the correct way.

- Ask the doctor or pharmacist to make a medication plan that fits your schedule.
- Use special pill boxes that have sections to put medication for different days and different times of the day.
- Ask about automatic pill boxes that can be set to open at specific times.



Next Step in Care

Medication Management Form

Patient name: _____ Date of birth: _____

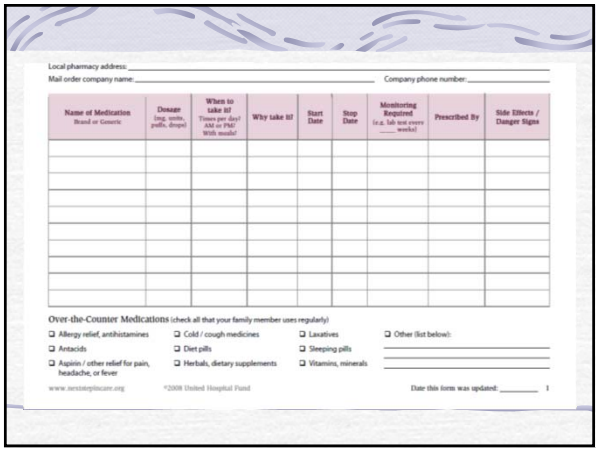
Local pharmacy name: _____ Pharmacy phone number: _____

Local pharmacy address: _____

Mail order company name: _____ Company phone number: _____

Name of Medication Brand or Generic	Dosage (mg, units, puffs, drops)	When to take it? Times per day? AM or PM? With meals?	Why take it?	Start Date	Stop Date	Monitoring Required (e.g. lab test every ____ weeks)	Prescribed By	Side Effects / Danger Signs

Over-the-Counter Medications (check all that your family member uses regularly)



Local pharmacy address: _____

Mail order company name: _____ Company phone number: _____

Name of Medication Brand or Generic	Dosage (mg, units, puffs, drops)	When to take it? Times per day? AM or PM? With meals?	Why take it?	Start Date	Stop Date	Monitoring Required (e.g. lab test every ____ weeks)	Prescribed By	Side Effects / Danger Signs

Over-the-Counter Medications (check all that your family member uses regularly)

- ❑ Allergy relief, antihistamines
- ❑ Antacids
- ❑ Aspirin / other relief for pain, headache, or fever
- ❑ Cold / cough medicines
- ❑ Diet pills
- ❑ Herbals, dietary supplements
- ❑ Laxatives
- ❑ Sleeping pills
- ❑ Vitamins, minerals
- ❑ Other (list below):

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DISCUSS ADVANCE DIRECTIVES

- Advance directives cover two kinds of information:
  - The kinds of treatments that your family member does or does not want
  - Who will be the person who can make health care decisions if your family member is unable to do so

OTHER HARD-WIRED NEEDS

- Follow-up appointment with the patient's primary care provider and specialist if appropriate.
- Series of appointments for physical or occupational therapy.
- Definite transportation to community appointments.

WHEN CAREGIVING ENDS

- Discuss grief as a natural feeling
- Experiences you had – good and bad – will stay with you forever
- How you coped with care giving will make a difference
- There is life after care giving

THANKS!

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