Nurse Case Managers & Social Workers: Relationship Best Practices Part II

Toni Cesta & Bev Cunningham

RELIAS LEARNING

Speakers

- **Toni Cesta**, PhD, RN, FAAN

Founding partner of Case Management Concepts, LLC. 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. She has been active in the research and development of Case Management for over 20 years.

- **Beverly Cunningham**, MS, RN, ACM

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 the former Vice President of Resource Management at Medical City Dallas Hospital.

OBJECTIVES

- Describe the case management process as it relates to the role of a social worker.
- Describe how social workers can maintain compliance with the CoPs on discharge planning.
- Describe family caregiver's role as part of the interdisciplinary care team.

The Case Management Process

- Step 1: Case Finding / Screening and Intake
- Step 2: Assessment of Patient Needs
- Step 3: Identification of Actual and Potential Problems – Service Delivery Planning
- Step 4: Linking the Patient to What they Need
- Step 5: Implementation of the Interdisciplinary Plan of Care
- Step 6: Evaluation of Patient Care Outcomes / Monitoring the Delivery of Patient Care Services
- Step 7: Patient Discharge and Disposition
- Step 8: Repeating the Process / On-Going Evaluation

STEP 1: CASE FINDING

- Each day every new admission must be identified
- If the patient was transferred to you from another unit, be sure you get hand-off communication from the prior Social worker
- If you are transferring the patient off your unit, be sure to include a written summary and provide a verbal hand-off to the receiving social worker

STEP 2: ASSESSMENT OF PATIENT NEEDS

- Begins immediately after admission or within one business day. The case manager will:
  - Review the patient's current and prior medical records
  - Interview physician
  - Interview patient and family
  - Complete admission assessment tool

ASSESSMENT OF PATIENT NEEDS

- By obtaining the initial assessment on the day of admission, patients needing a social work intervention will be referred to the social worker as soon as possible.
- Patients can be identified by the social worker or referred by any member of the interdisciplinary care team at any time.

CASE MANAGEMENT – ADMISSION ASSESSMENT

As needed the case manager will identify:

- Patients needing social work - make referral.
- Patients needing referral to home care – make referral.
- If the social work is in charge of the discharge plan, then you should discuss with patient and/or family right to choose post-discharge provider.

BE SURE YOU HAVE THE FOLLOWING INFORMATION

- Information obtained from patient / family / ED / prior medical records
- Primary contact
- Special needs
- Mental status
- Living situation
- Type of housing
- Stairs
- Elevator
- DME used prior to admission

BE SURE YOU HAVE THE FOLLOWING INFORMATION (Continued)

- Anticipated discharge plan
- Transportation
- Factors affecting discharge
- Discussed with patient/family that info might be shared with providers for purpose of obtaining services
- Discussed with patient / family the right to choose provider
- Patient / family in agreement with and participated in discharge plan

INITIAL INTAKE NOTE ONCE YOU HAVE BEEN REFERRED THE PATIENT

Step 1: Review the current medical record, including all relevant diagnostic test results, such as lab values and radiology reports

Step 2: If the patient was admitted through the emergency department, review all available EMS notes

Step 3: Obtain and review prior medical records if available

Step 4: Discuss the patient with the admitting physician

Step 5: Interview the patient and/or family

DAILY DOCUMENTATION

- Day *X* of an expected length of stay of *Y* days

Example: “It is day two of a five day expected length of stay”

- Outcomes of Care – Your Psychosocial interventions and discharge planning process
- Changes to the plan based on the patient’s clinical outcomes and care progression
- Anticipated discharge plan

DAILY DOCUMENTATION

- Any updates to the patient's social, financial or family situation
- The status of any referrals made
- Any legal issues, such as guardianship or immigration status
- Any patient education needs

EXAMPLES OF FACILITATION/ COORDINATION ITEMS

- Tests
- Treatments
- Procedures
- Preps
- Consults
- In-patient surgery

EXAMPLES OF PATIENT EDUCATION

- Family dynamics
- Medication compliance
- Disease process
- Equipment for home use
- When to call the doctor
- Potential complications

EXAMPLES OF REFERRALS

- Psychiatry
- Home care
- Hospice care
- Palliative care
- Coping / grieving
- Clergy
- Nutritionist

EXAMPLES OF DISCHARGE ITEMS

- Appropriateness
- Selection process
- Patient choice provided
- Family support
- Important Message from Medicare
- Patient choice process for home care and/or skilled nursing facility

FOLLOW-UP NOTES

- Daily and whenever an intervention takes place
- Patient and family education provided
- Discharge delay issues
- Family concerns
- Discussion process in selecting discharge destination

DON'T NEED TO DOCUMENT

- Physical assessment
- Medical history
- Identified system or practitioner delays
- Subjective judgments

DISCHARGE NOTE

- Summarize the stay from the social worker case management point of view. Focus on discharge destination and patient's readiness for discharge. Be specific.

EXAMPLE OF A GOOD SOCIAL WORK NOTE

1/5/2017 10:00 a.m.

This is day 2 of an expected length of stay of five days. The patient has completed diagnostic testing and an MI has been ruled in. The patient has reported that she is afraid of her husband and does not want him to know her diagnosis. The interdisciplinary care team has been notified of this request, including the physician. A referral to an out-patient community resource for her to manage her issues with her husband will be made prior to the patient's discharge.

Mary Smith MSW

Pager: 1234

EXAMPLE OF A POOR SOCIAL WORK NOTE

1/5/2017 10:00 a.m.

Saw patient at bedside. Will follow.

Mary Smith MSW

Pager: 1234

STEP 3: IDENTIFICATION OF ACTUAL AND POTENTIAL PROBLEMS – CARE PLANNING

- Following review and collection of patient information, a case management plan should be developed to include:
  - The inpatient plan of care
  - Any barriers to achieving the outcomes of the plan of care
  - The items needed to meet the patient's post-discharge needs

STEP 4: LINKING THE PATIENT TO WHAT THEY NEED

- Collaborate with the RN case manager to ensure that the service plan you are developing will be covered by the patient's insurance plan
- If not covered, consider alternative arrangements
- Provide the "choice list" to the patient and family
- Discuss these barriers with the interdisciplinary care team and the patient

STEP 5: IMPLEMENTATION OF INTERDISCIPLINARY PLAN OF CARE

- Ensure that all approvals have been obtained and that all arrangements have been made in the community
- Follow-up as needed

THE ROLE OF THE SOCIAL WORKER IN PATIENT FLOW

- Correct patient flow barriers as they occur
  - Patient care rounds
  - Psychosocial discharge planning
- Collect data for on-going performance improvement

INTERDISCIPLINARY PATIENT CARE ROUNDS

- Critical to patient flow
- Should focus on
  - In-patient plan of care
  - Expected outcomes of care
  - Barriers to care
  - Discharge planning

TALKING POINTS FOR INTERDISCIPLINARY ROUNDS

GENERAL INFORMATION REGARDING ROUNDS

- Rounds occur Monday through Friday from 9:30-10:00 a.m.
- All members of the interdisciplinary team are expected to attend
- The physician and nurse manager will facilitate the rounds

- **PROCESS FOR ROUNDS**

TALKING POINTS FOR INTERDISCIPLINARY ROUNDS

PROCESS FOR ROUNDS

PHYSICIAN/NURSE SHOULD DISCUSS

- The plan of care
- The expected outcomes of care
- The expected length of stay
- Discharge plan
- Barriers to care

TALKING POINTS FOR INTERDISCIPLINARY ROUNDS

CASE MANAGER SHOULD DISCUSS

- Status of discharge plan
- Barriers to care and to discharge
- Any reimbursement issues
- Expected LOS

SOCIAL WORKER SHOULD DISCUSS:

- Any psychosocial issues
- Andy barriers to discharge

STEP 6: EVALUATION OF PATIENT CARE OUTCOMES / MONITORING THE DELIVERY OF PATIENT CARE SERVICES

Timely:

- Transition off IV antibiotics
- Removal of foley catheter
- Removal of pressure devices
- Removal of drains
- Ambulation
- Diet progression

STEP 7: PATIENT DISCHARGE AND DISPOSITION

TIMELY TRANSITIONS

Four points to consider

1. The provision of quality care in the initial hospitalization
2. Adequate discharge planning
3. Adequate post-discharge follow-up
4. Improved coordination between inpatient and outpatient healthcare teams

DEFINITION OF DISCHARGE PLANNING

Process in which a systematic approach is used to facilitate the transition of the patient from one level of care to another

- Planning stay from door to door
- Collaboratively determining level of care
- Connecting post-acute care services
- Transitioning patients to next level of care
- Assessment of the family caregiver

CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

- Discharge planning process must applies to all patients (“process to decide what a patient needs for a smooth move from level to another”)
- Policies and procedures specified in writing

(a) Standard: Identification of patients in need of discharge planning

1) Must identify at an early stage of hospitalization all patients likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning

(b) Standard: Discharge planning evaluation

1) Must provide discharge planning evaluation to identified patients (paragraph (a) of this section), and to other patients upon the patient’s request, request of person acting on patient’s behalf, or request of the physician

2) Registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise development of, the evaluation

CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

3) Discharge planning evaluation must include evaluation of likelihood of patient needing post-hospital services and availability of the services
4) Discharge planning evaluation must include evaluation of likelihood of patient's capacity for self-care or possibility of patient being cared for in environment from which he or she entered hospital
5) Hospital personnel must complete timely evaluation so appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge
6) Hospital must include discharge planning evaluation in patient's medical record for use in establishing appropriate discharge plan and must discuss results of evaluation with patient or individual acting on his or her behalf

CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

c) Standard: Discharge plan.

1) Registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise development of, discharge plan if discharge planning evaluation indicates need for discharge plan

CMS recommends discharge planning process performed at least 48 hours before discharge and requires surveyors to make sure discharge wasn't delayed because discharge planner didn't do timely discharge evaluation

If hospitals don't evaluate all patients for post-discharge needs, they should have a system to ensure there is a way for discharge planning staff to learn if a patient's condition changes to the point that he or she will need post-discharge services

CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

(5) As needed, patient and family members or interested persons must be counseled to prepare for post-hospital care

CMS wants discharge planners to assess

- **That patient's discharge needs can be met in their previous living environment**
- **That patients and/or family members have ability to take care of patient's needs after discharge**
- **If not, discharge planners should make sure that there are community-based services that can provide care and needed services are in place when patient is discharged**

CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

(6) Hospital must include in discharge plan list of HHAs or SNFs available to patients participating in Medicare program, and that serve geographic area (as defined by the HHA) in which patient resides, or in case of SNF, in geographic area requested by patient; HHAs must request to be listed by hospital

(i) List must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by discharge planning evaluation

(ii) For patients enrolled in managed care organizations, hospital must indicate availability of home health and post-hospital extended care services through individuals and entities that have contract with the managed care organizations

CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

(iii) Hospital must document in medical record that list was presented to patient or to individual acting on patient's behalf

(7) Hospital, as part of discharge planning process, must inform patient or patient's family of freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when they expressed; hospital must not specify or otherwise limit qualified providers available to patient

(8) Discharge plan must identify any HHA or SNF to which patient referred in which the hospital has a disclosable financial interest, and any HHA or SNF that has disclosable financial interest in a hospital under Medicare

CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

(d) Standard: Transfer or referral

Hospital must transfer or refer patients, along with necessary medical information, as needed, for follow-up or ancillary care

(e) Standard: Reassessment

Hospital must reassess its discharge planning process on an on-going basis; reassessment must include review of discharge plans to ensure they are responsive to discharge need.

DISCHARGE NOTE

1. Patient's discharge plan is _____
2. Transportation at discharge is _____
3. Patient educated that transport is a multi-passenger wheelchair transport
4. Patient / family understand and in agreement with discharge plan as stated above

POST-DISCHARGE FOLLOW-UP

- Phone calls to patients after discharge
  - Did home care arrive?
  - Did you fill your prescriptions?
  - Did DME equipment arrive?
  - Are you taking your medications?
  - When is your next md appointment?
  - Do you have a way to get to the md appointment?

HOME CARE IS CRITICAL

- Make sure patients have at least one home visit
- Medication reconciliation can be repeated by home care
- Patient education can be reinforced

Identification of Patients for Referral to Home Care Services: Guidelines for Home Care Assessment

- Patients requiring assessments/education relating to:
  - New diagnosis
  - New medications or change in medications
- Change in patients 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

DEFINITION OF HOMEBOUND STATUS

Considerable and taxing effort may include:

- Needs help of another person to leave home
- Needs assistive devices to leave home
- Needs special transport
- Leaving home exacerbates symptoms (e.g. shortness of breath, pain, anxiety, confusion, fatigue)
- Patient who leaves home infrequently for short durations or for health care MAY STILL be considered homebound. This may include patients who attend:
    - Adult day programs
    - Outpatient medical care
    - Religious services
    - Dialysis
    - Hairdresser

STEP 8: REPEATING THE PROCESS

- Sometimes things don't go as expected and parts of the process need to be repeated or changed

INTEGRATING FAMILY CAREGIVERS INTO THE ROLE OF THE SOCIAL WORKER

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

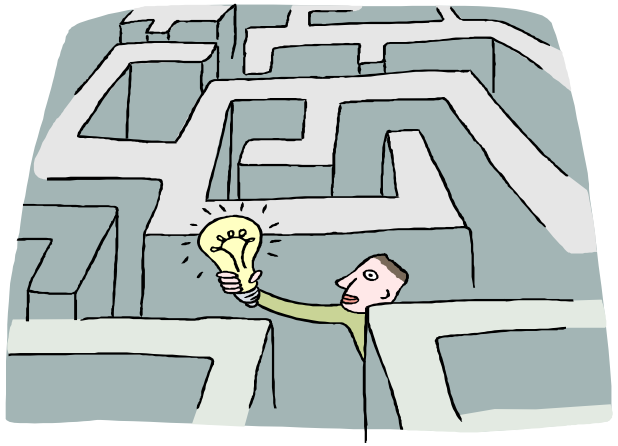
- Take care of someone who has a chronic illness or disease
- Manage medications or talk to doctors and nurse's on someone's behalf
- Help bathe or dress someone who is frail or disabled
- Take care of household chores, meals or bills for someone who cannot do these things alone

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

IT IS IMPORTANT THAT THEY SEE THEMSELVES AS A FAMILY CAREGIVER

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

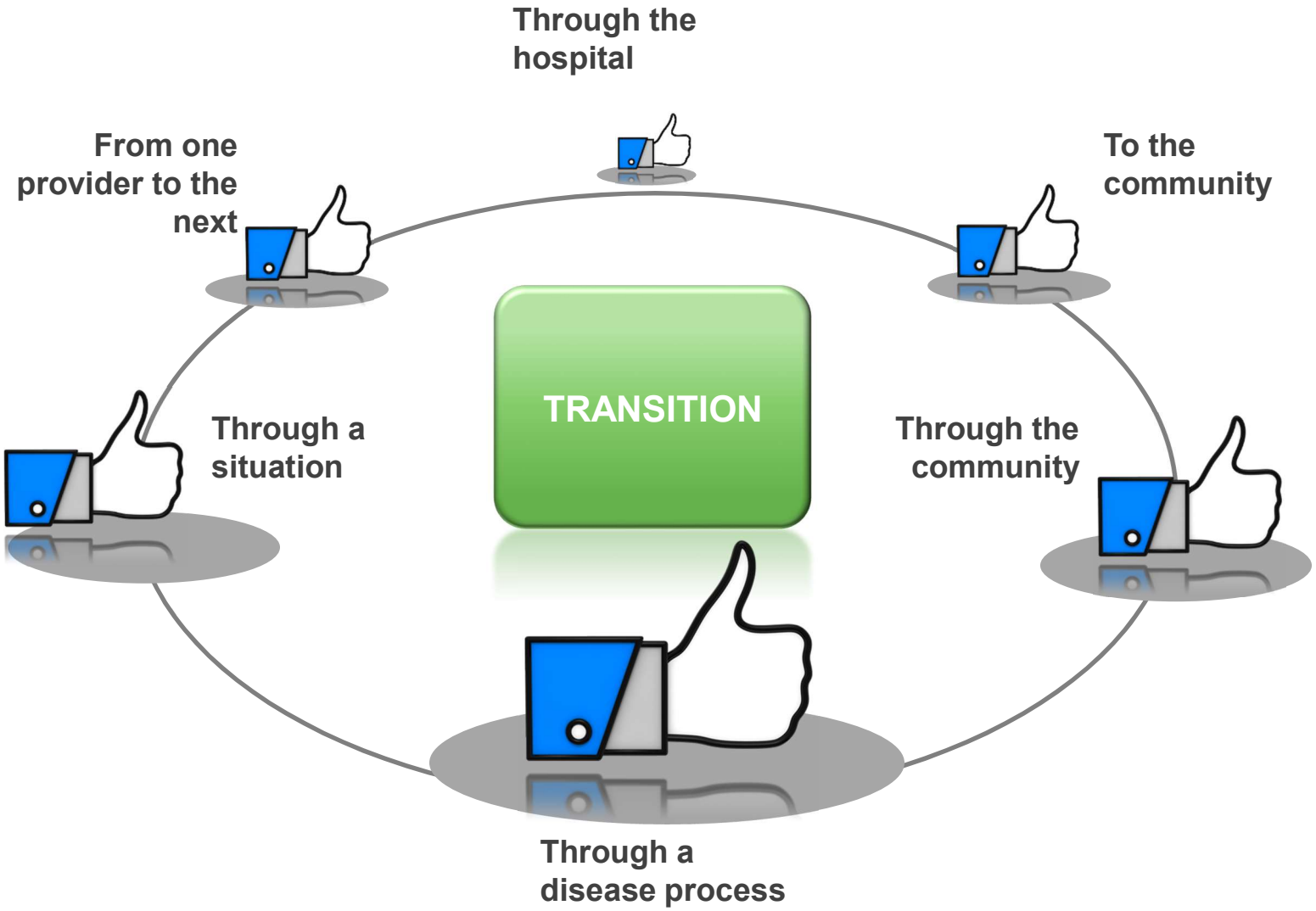
WHEN DOES CAREGIVING START

- 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

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

RELIAS | LEARNING

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

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)

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

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

CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

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

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
Family Caregivers & Health Care Professionals Working Together

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

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

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)	❑	❑	❑

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

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

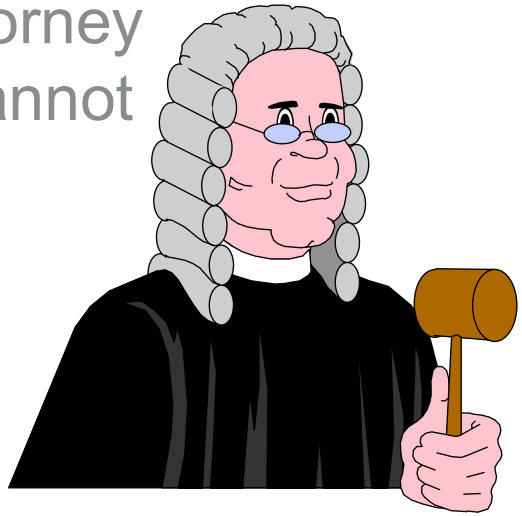
For the full form go to nextstepincare.org

HANDLING TRANSITIONS

- Can be upsetting, disruptive, confusing
- Each transition brings:
  - New providers
  - New rules and 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



EDUCATING THE FAMILY CAREGIVER

- 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

EDUCATING THE FAMILY CAREGIVER

- 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

Personal Health Record

Your Family Member's

Personal Health Record

A. Identification		
Name (Last)	(First)	(Middle)
Primary Address		
City	State	Zip Code

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
Family Caregivers & Health Care Professionals Working Together

Personal Health Record

B. Emergency Contacts

In Case of Emergency, Notify (Primary Contact)		Relationship	
Address	City	State	Zip Code
Home Phone	Work Phone	Cellular Phone	
In Case of Emergency, Notify (Secondary Contact)		Relationship	
Address	City	State	Zip Code
Home Phone	Work Phone	Cellular Phone	

Next Step in Care
Family Caregivers & Health Care Professionals Working Together

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

Member (ID) Number:

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

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

Document Location (physical location, for ex. safe deposit box)

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

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

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
- 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

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

Next Step in Care
Family Caregivers & Health Care Professionals Working Together

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):

_____

_____

_____

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

RESOURCES

- Cesta & Tahan (2017). The Case Manager's Survival Guide: Winning Strategies in the New Healthcare Environment. Destech Publications, Lancaster, PA.
- Social Work Today (2017). Great Valley Publishing, Spring City, PA.
- Brintzenhofe & Gilbert (2017). Social Work in Healthcare, Vol. 56. On-Line Publication.
- Case Management Roles Must Evolve to Meet Future Needs (Aug., 2017). Hospital Case Management, AHC Media, Cary, N.C.
- Cesta, T. (Dec, 2016). The Process of Managing Long Stay and Difficult-to –Discharge Patients (De. 2016). Hospital Case Management, Cary, N.C.

IT'S TIME FOR QUESTIONS

Toni Cesta
cestacon@aol.com

Bev Cunningham
bevcmc@hotmail.com

www.casemanagementconcepts.com

THANK YOU

RELIAS | LEARNING