Take Charge of Your Money

A University of Hawai‘i Cooperative Extension Service Project

www.ctahr.hawaii.edu/tcym
Course Objectives

- Increase your knowledge about financial planning
- Improve your ability to make informed decisions
Transitions in Care
Presenter

Bonnie Castonguay

Founder & CEO

Ho’okele Health Navigators, LLC
Lesson Objectives

- Understand the challenges with transitions of care and its impact on the elderly
- Learn how to advocate for your loved one who is in a hospital or nursing facility
- Become aware of what is needed for a safe discharge home
Challenges with the Healthcare System

- Hospital Readmission
- Transition Issues
- The Patient
Many programs address patient readmissions by:

- Improving discharge planning processes
- Coordinating care post-discharge

Readmission rate is 19.6% within 30 days of discharge (nationally)

The cost for repeat hospital stays is estimated at $15 billion
Transition Problems

- Decreased independence in daily living
- Difficulty administering medication
  - Forget to take medication
  - Unable to read labels
  - Instill eye drops
Transition Problems (continued)

- Lack of understanding:
  - Which symptoms to watch for
  - When to call for help
- Dependence on others for household activities
- Social isolation
The one person present in all the settings is the patient.
Medication Errors

- Harm an estimated 1.5 million people each year, in the U.S.
- Costs at least $3.5 billion annually
- An estimated 66% of medication errors occur during transitions

*Medicare Payment Advisory Commission, June 2009*
Readmissions

- Lack of understanding of disease
- Lack of clear instructions on what to do at home
- Patients discharged with a clear understanding of their discharge instructions cost $412 less (per patient) that those who did not (US Department of Health & Human Services, 2009)
- Lack of follow up with MDs
He ran a business all his life. Now he lives alone. He was doing fine until this year.

- Daughter helps with chores and shopping
- Starting to forget to eat and shower
- Forgot to take his heart medications and was admitted to the hospital for congestive heart failure.
- Wants to return home and refuses to go to one of “those old people places.”
Challenges Families Face

- Little planning time
- Decision-making in a crisis
- Overwhelmed by details
- Financial resources
- Not aware of all the resources
Discharge Preparation

• Assessment of Mr. Ching’s clinical and functional status to determine his needs at home
• Discharge plan that addresses problems and actions
Basic education on congestive heart failure -- the disease, diet, activity level, and medications

Community resources to call for

MD follow-up appointments

Services at home

Emergency

What to do in case of an emergency

Diuretics
Tools

Checklists

• Assist with training and education

• Promotes consistency of practice
Example Questions:

- I have been involved in decisions about what will take place after I leave the facility.
- I understand what my medications are, how to obtain them and how to take them.
- I understand what symptoms I need to watch our for and whom to call should I notice them.

*Tool developed by Dr. Eric Coleman, UCHRC, HCPR*
## Simple Medication Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication</th>
<th>Dose Given</th>
<th>Frequency</th>
<th>Time</th>
<th>AM/PM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Challenges at Home

- Risk of falls
- Ability to call for help
- Help with activities of daily living
- Meal preparation
- Medication compliance
- Housekeeping
- Transportation to MD visits
- Bill paying
Case management:

“Collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.”
Different Names

- Case Managers
- Care Coordinators
- Transitional Care Coaches
- Patient Advocates
- Health Navigators
There is a need for a family member, friend or professional to advocate in the hospital setting for your loved one.
Summary

- Discharge plan should include:
  - Basic education on disease
  - Review of medications
  - Follow up appointment
  - Community resources for assistance at home
- Consider professional help when needed
Website & TV Channels

Take Charge of Your Money

- Visit Us
  - www.ctahr.hawaii.edu/tcym

- TV channels
  - 354
  - 355
We would like to thank the following groups for their support:

- University of Hawai'i at Mānoa
  - College of Tropical Agriculture & Human Resources, Cooperative Extension Service, Department of Family & Consumer Sciences
  - Information Technology Services-Academic Technologies

- Ho'okele Health Navigators, LLC