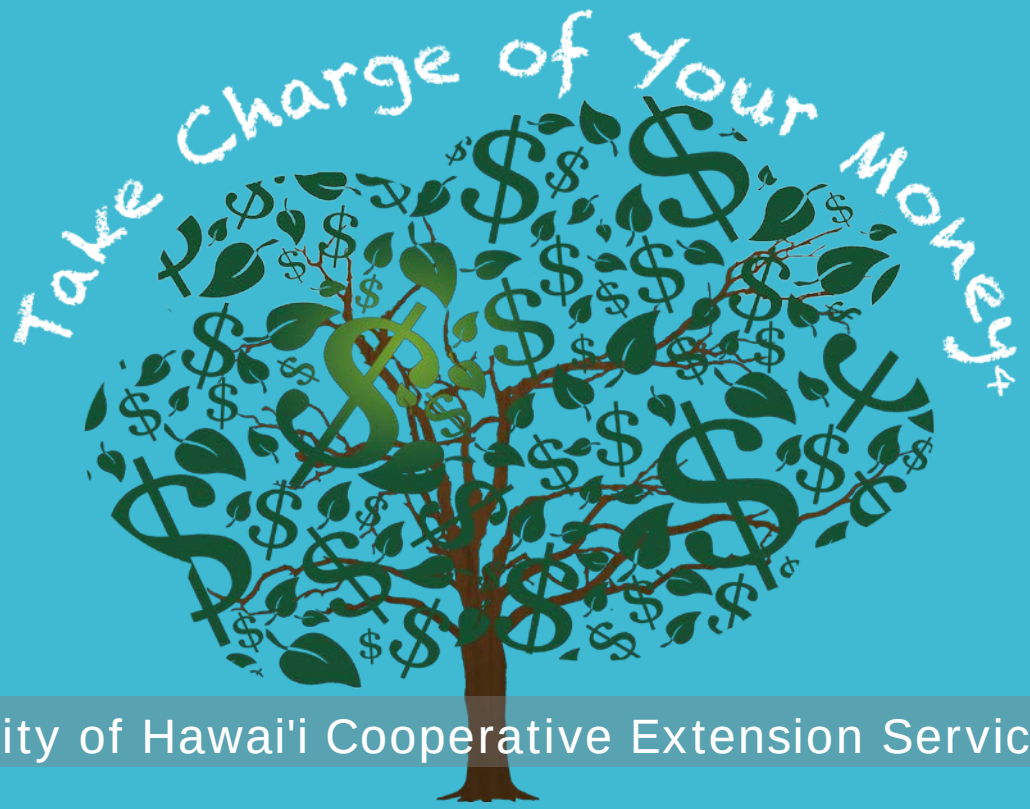
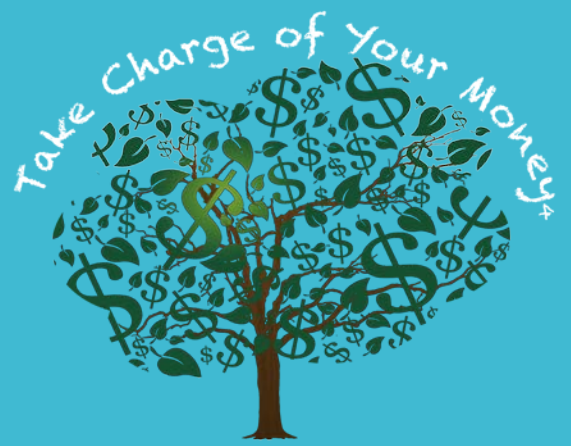


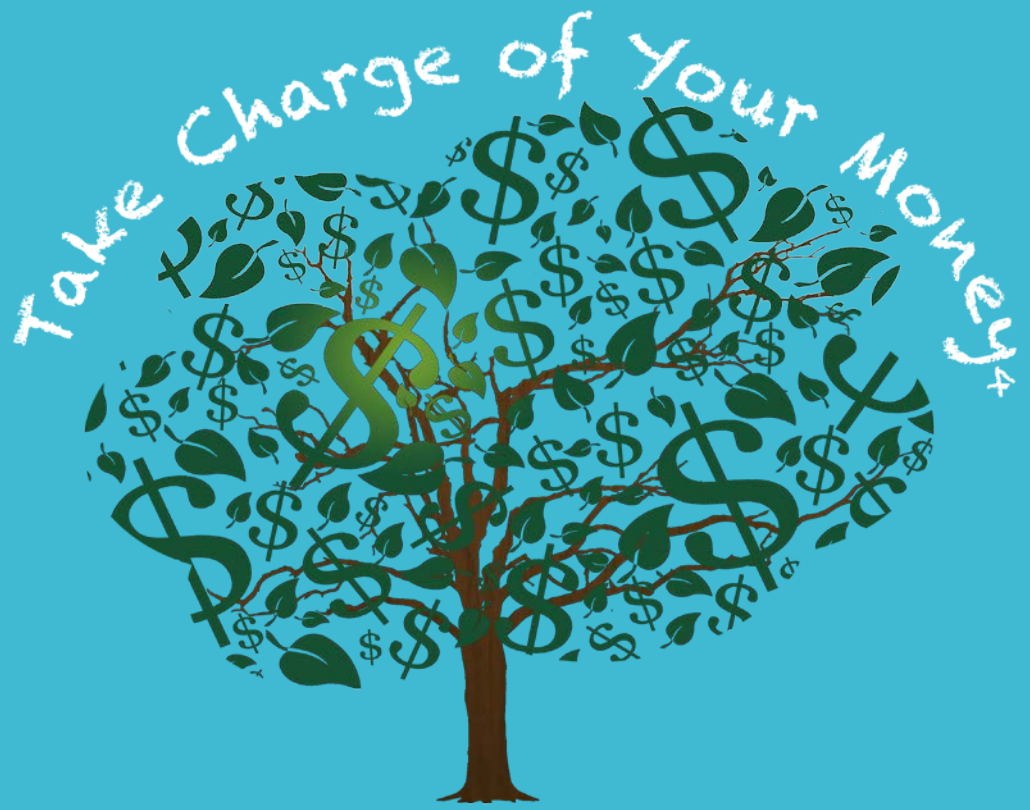
A University of Hawai'i Cooperative Extension Service Project

www.ctahr.hawaii.edu/tcym

Course Objectives

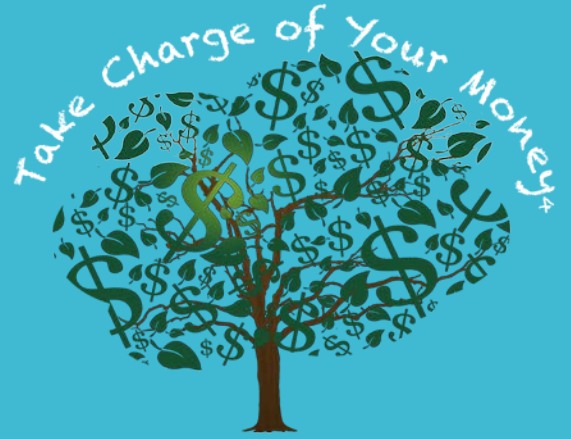


- Increase your knowledge about financial planning
- Improve your ability to make informed decisions



Transitions in Care

Presenter



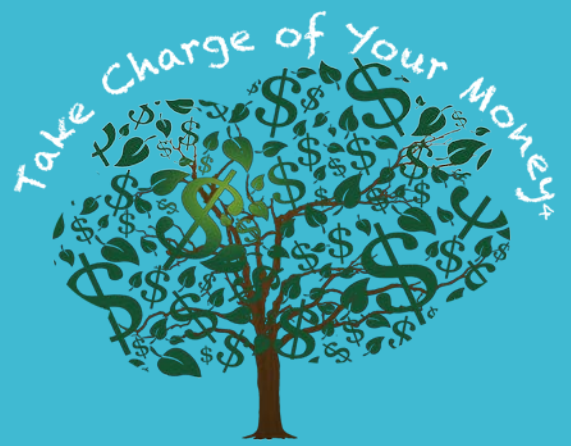
HO'OKELE

Bonnie Castonguay

Founder & CEO

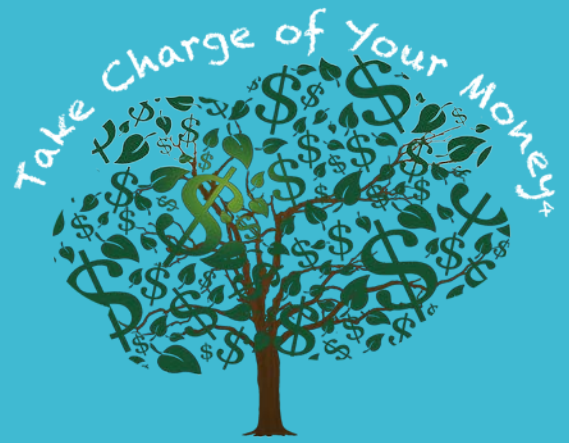
Ho'okele Health Navigators, LLC

Lesson Objectives



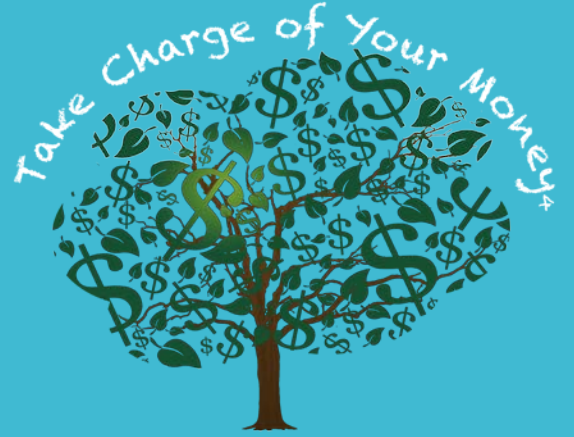
- Understand the challenges with transitions of care and its impact on the elderly
- Learn how to advocate for your loved one who is in a hospital or nursing facility
- Become aware of what is needed for a safe discharge home

Challenges with the Healthcare System



- Hospital Readmission
- Transition Issues
- The Patient

Hospital Readmission



- 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

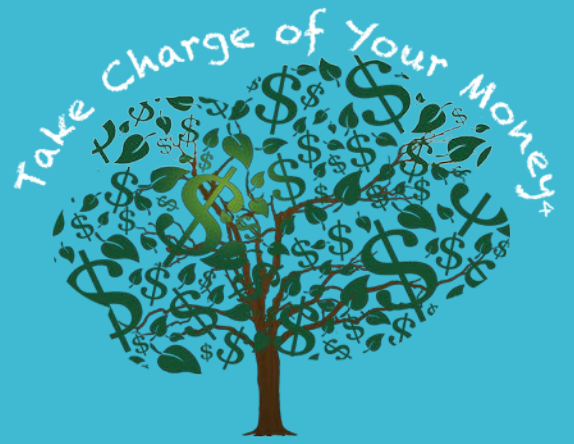
Transition Problems

- 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 Patient



The one person present in all the settings is the patient

ER → Hospital → Skilled Facility → Home

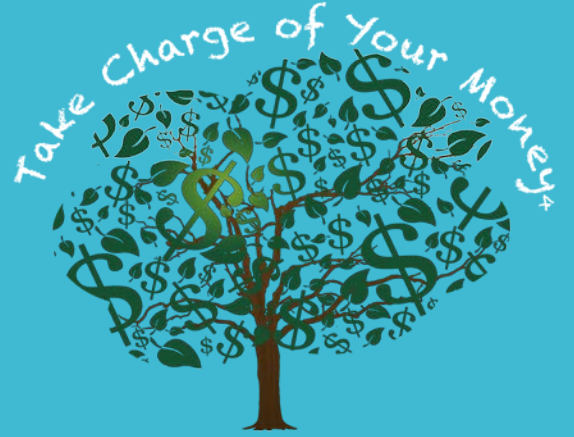
Major Causes for Readmissions

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

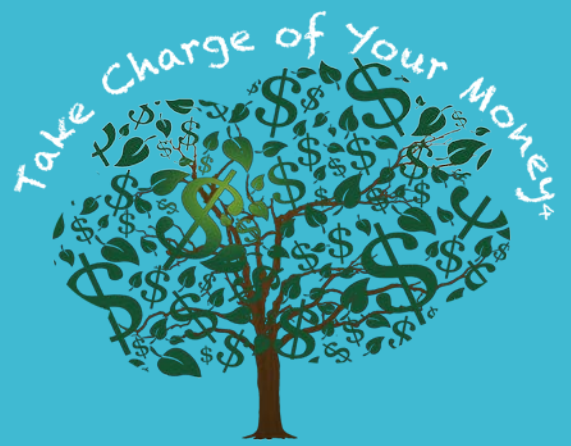
Medicare Payment Advisory Commission, June 2009

Readmissions



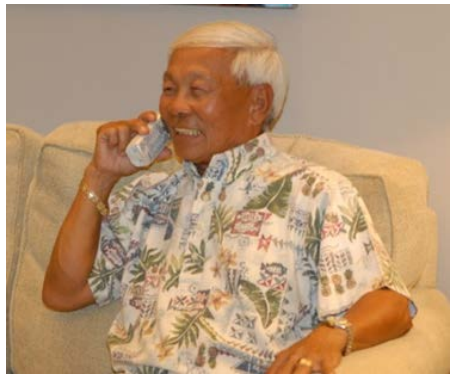
- Lack of understanding of disease
- Lack of clear instructions on what to do at home
- Patients discharged with a clear understanding of their discharge instructions cost $412 less (per patient) that those who did not *(US Department of Health & Human Services, 2009)*
- Lack of follow up with MDs

Mr. Independent Ching

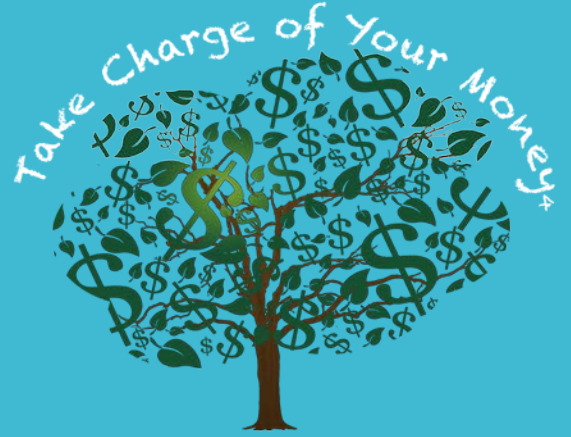


He ran a business all his life. Now he lives alone. He was doing fine until this year.

- 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."

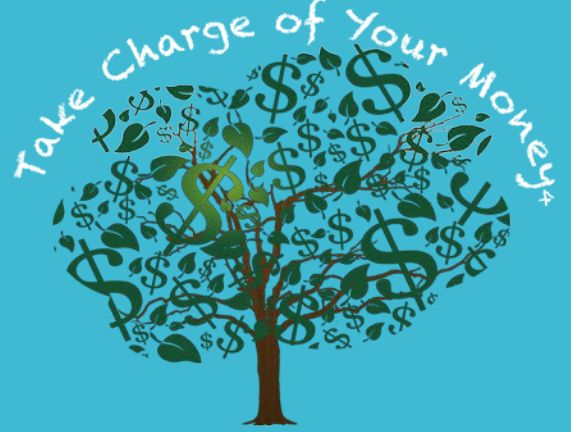


Challenges Families Face



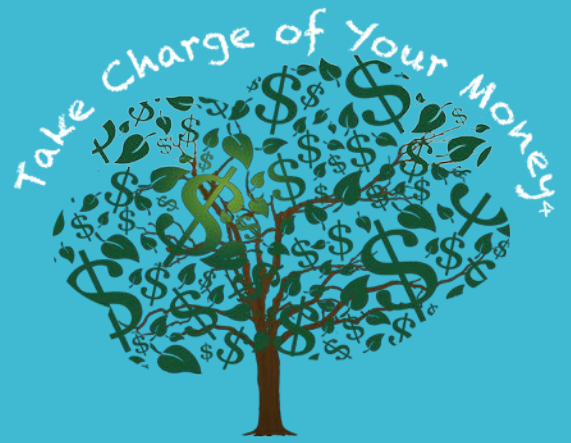
- Little planning time
- Decision-making in a crisis
- Overwhelmed by details
- Financial resources
- Not aware of all the resources

Discharge Preparation



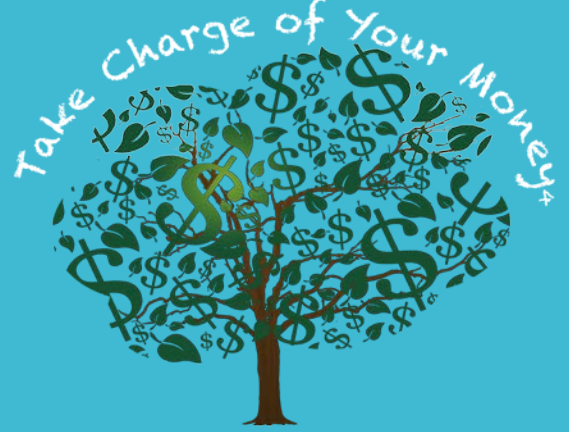
- Assessment of Mr. Ching's clinical and functional status to determine his needs at home
- Discharge plan that addresses problems and actions

Discharge Preparation



- Basic education on congestive heart failure -- the disease, diet, activity level, and medications
- Community resources to call for services at home
- MD follow-up appointments
- What to do in case of an emergency

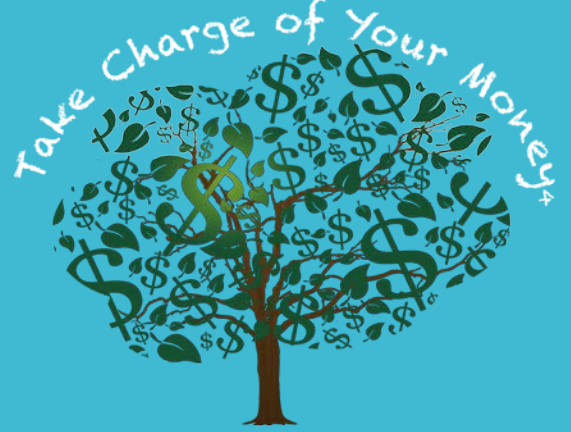
Tools



Checklists

- Assist with training and education
- Promotes consistency of practice

Discharge Checklist

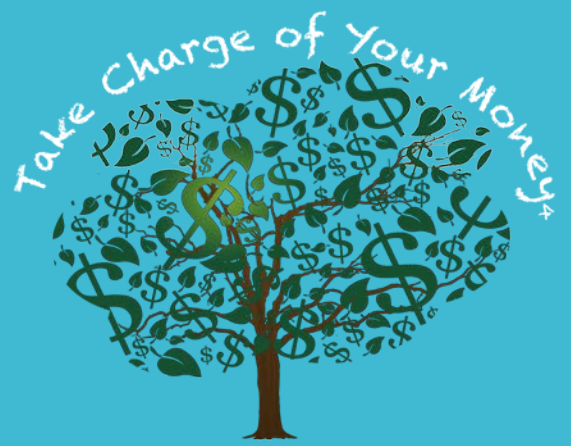


Example Questions:

- ❑ 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

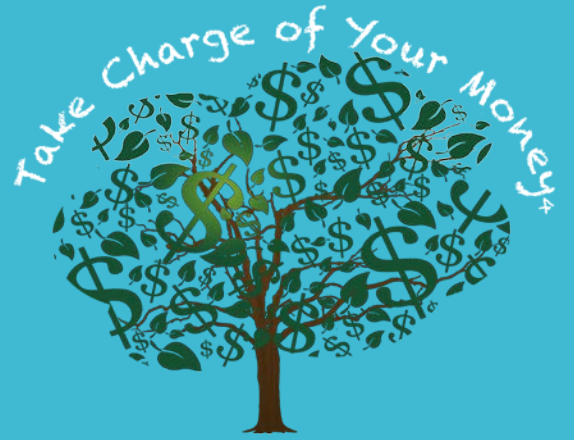
Simple Medication Record



Medication Record

Date	Medication	Dose Given	Frequency	Time	AM/PM

Challenges at Home



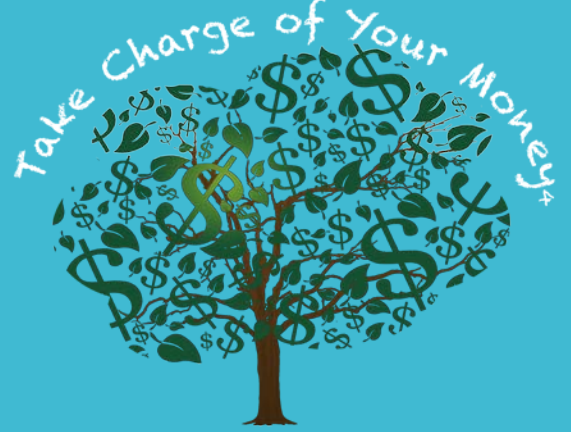
- Risk of falls
- Ability to call for help
- Help with activities of daily living
- Meal preparation
- Medication compliance
- Housekeeping
- Transportation to MD visits
- Bill paying

Professional Assistance

Case management:

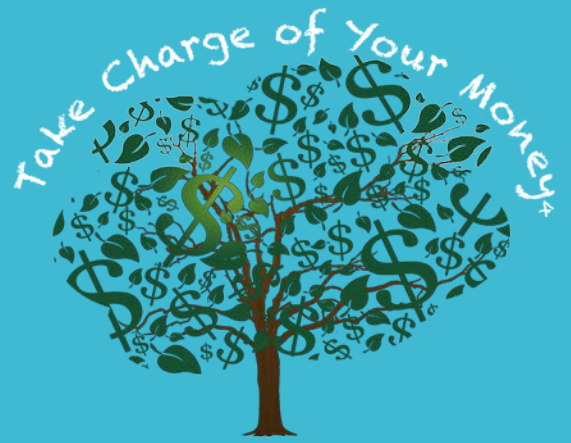
“Collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes."

Different Names



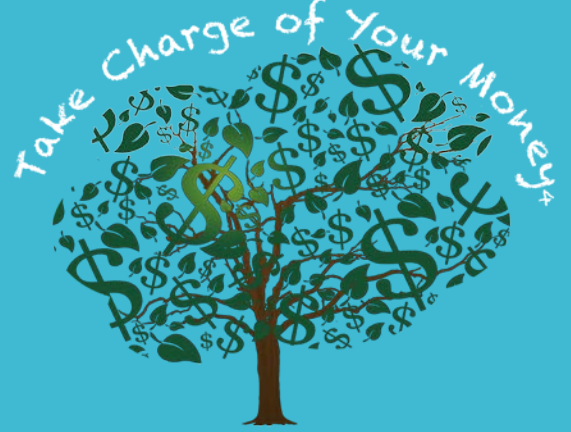
- Case Managers
- Care Coordinators
- Transitional Care Coaches
- Patient Advocates
- Health Navigators

Advocate



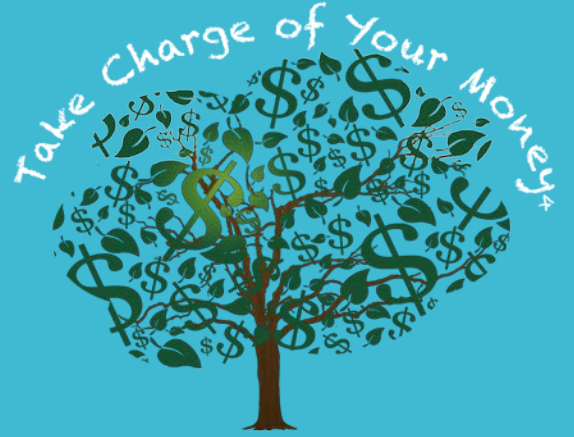
There is a need for a family member, friend or professional to advocate in the hospital setting for your loved one

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



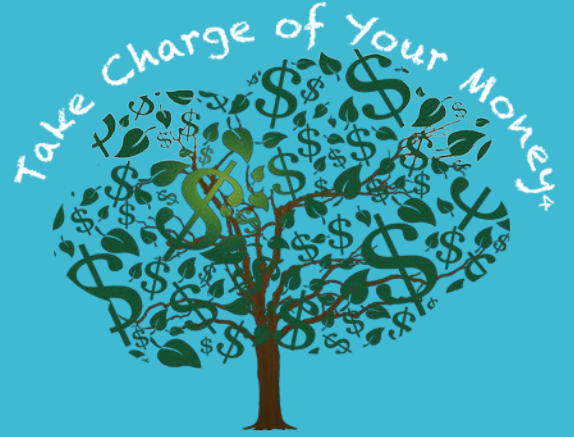
Take Charge of Your Money$_4$

- Visit Us

www.ctahr.hawaii.edu/tcym

- TV channels
  - 354
  - 355

Credits



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  - Information Technology Services-Academic Technologies
- Ho'okele Health Navigators, LLC