



# CAREGIVER FRIENDLY COMMUNITIES ASSESSMENT

## Best Practices: Care Management Services



Caregivers frequently cite challenges in managing their loved ones' healthcare – including the coordination of in-home nursing and other in-home help, managing prescription medications, coordinating appointments and transportation for doctor visits, and finding information about the specific illness that loved ones are being affected by and its implications for caregiving responsibilities.

The Caregiver Friendly Communities Assessment scores this domain in two ways: 1) assessing hospital discharge care transition services, and 2) assessing post-discharge support to caregivers. Below, you'll find the scoring factors along with recommended practices.

### 1. Assessing Hospital Discharge & Care Transition Services

The point in time when a patient leaves the hospital after treatment is an especially crucial moment of contact between healthcare providers and the patient's caregiver. The information and support provided to a caregiver during this time can directly impact patient readmission rates and ability of a caregiver to successfully manage care at home. In a national review of 62 peer-reviewed journal articles on caregiving, caregiver concerns were largely found to be unmet with specific deficits in the areas of: 1) caregivers not receiving complete explanations of symptoms and alternative treatments for patients; 2) lack of basic disease information; and 3) lack of information about how to prepare for the patient coming home (Washington, 2011).

As of August, 2016, Michigan law requires hospitals to enact patient discharge procedures that include designating a caregiver, communicating and consulting with a caregiver about the patient's discharge, and issuing linguistically and culturally understandable information in the discharge plan. Hospitals are expected to comply and document their related policies and procedures. [https://www.dykema.com/resources-alerts-new-michigan-law-strives-to-make-hospital-discharges-easier-for-patients\\_04-19-2016.html](https://www.dykema.com/resources-alerts-new-michigan-law-strives-to-make-hospital-discharges-easier-for-patients_04-19-2016.html)



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Several researchers have investigated various aspects of the hospital discharge process with the following findings on best ways to support caregivers at patient discharge:

- In a systematic review of 15 different studies, research indicates that hospitals that involve caregivers in the discharge planning of patients see a 25% reduction in hospital readmissions in 90 days along with shorter hospital stays and lowered costs (Rodakowski, 2017).
- In a qualitative study of 26 caregivers, research found that caregivers are better equipped to patients discharged from the hospital after intensive care unit (ICU) care if they are provided with: 1) lists and instructions for patient care; 2) support from home care nurses; 3) phone calls from health providers to check on medical appointment scheduling; 4) illness-specific information and current status of disease progression, if applicable (Czerwonka, 2015).
- Personalized patient discharge letters that are shared with patients and their caregivers, written in plain (non-medical) language and which describe the patient's road to recovery, possible barriers to recovery and provides some problem-solving skills for the discharge have been found to increase patient and caregiver satisfaction and increase effective discharge planning (Buurman, 2016).
- Caregivers should have their needs assessed by a primary care physician - especially at the care recipient's hospital discharge and at end-of-life planning. Assessment should include perception of their own well-being, perceived challenges and benefits of caregiving, confidence in their abilities, and the need for additional support systems (Collins, 2011).

It's critically important for caregivers to not only be involved in the discharge planning of the care recipient, but also be provided with information about how to take care of the patient once home, information about the condition, and an opportunity to assess caregiver needs for optimum support. ***Recommended Practice: review the discharge processes at your local hospitals. Check to see if procedures include:***

- ***Written care instructions for caregivers in plain language***
- ***Individualized caregiver assessment***
- ***Information about post-discharge resources and services***
- ***Referral to care transitions programs***



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### 2. Post-Discharge Care Support

After the patient leaves the hospital and begins care by a caregiver - that moment is often the second most crucial time for support. In a study of 246 caregivers 89% indicated that resource referrals were the most common need (Black, 2013). Several other research studies point to the types of services that benefit caregivers in their role:

- Intensive geriatric social workers assigned to older adult patients discharged from the hospital improve health goal accomplishment, increase care satisfaction among older adults and their caregivers, and reduce emergency department visits and rehospitalizations (McAiney, 2017).
- Providing nurse-by-phone support, caregiver needs assessment, crisis intervention and coordination of care support improves caregiver preparedness to care for their loved one and reduces strain (Toye, 2016).
- Healthcare providers should assess caregivers' changing needs over time to help pinpoint services needed during a loved one's health status changes as well as implement a family-centered model of care to best support caregiver needs (Cameron, 2013).

Post-Discharge Care Support is assessed by the level of care transition support offered to caregivers in your region. **Recommended Practice: review the care transitions services available in your region for deficits. If none exist, work with community partners to set up care transition programs. Also, advocate for Michigan Medicare and Medicaid Assistance Program (MMAAP) or State Health Insurance Assistance Program (SHIP) volunteers to assist caregivers with securing health benefits, making claims, and filing complaints if none currently exist in your region.**

Caregiving in rural regions is particularly difficult with additional challenges due to the higher population of care-recipients and reduced population of those of caregiver ages, combined with greater geographic distance to services, reduced prevalence of respite and other caregiver support services. Churches and connection to faith-based organizations have been found to help bridge the gap in some areas (Monahan, 2013)

#### Sample Programs:

- Through the **Physician/AAA Partnership for Caregivers** at Aging Resources of Central Iowa, medical practitioners involved in the Family Caregiver Program refer caregivers of individuals diagnosed with dementia to the Area Agency on Aging,



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rather than waiting for caregivers to experience a crisis and then seek assistance. Upon receiving the referral, a Caregiver Specialist initiates a call to the caregiver to address caregivers' concerns and share resources over the phone or in face-to-face meetings. Caregivers learn about the disease process and are connected with services and programs available to them.

<https://www.agingresources.com/programs-services/family-caregiver-program/>

- Smeenk and colleagues found that family caregivers who received a home care intervention (which included a specialist nurse coordinator, a 24-hour nurse telephone service with access to a home care team, a collaborative home care case file, and care protocols) significantly improved caregiver quality of life at 1 week and 4 weeks after discharge from the hospital. The care dossier was used to assist with communication and coordination between caregivers and health professionals. The dossier included the lists of the patient's caregivers, discharge reports, nursing home case transfer reports, medication lists, and multidisciplinary reports. From these reports, specific patient intervention approaches were developed (Smeenk 1998).
- Rather than waiting for caregivers to experience a crisis and seek assistance, medical practitioners involved in the **Family Caregiver Program** in Central Iowa refer caregivers of individuals diagnosed with dementia to the Area Agency on Aging. Upon receiving the referral, a Caregiver Specialist initiates a call to the caregiver, who may be overwhelmed with the diagnosis and uncertain where to turn for assistance. Caregiver Specialists address caregivers' concerns and share resources over the phone or in face-to-face meetings. Caregivers learn about the disease process and are connected with services and programs available to them. No new funding streams were used for this program. Title III E Older Americans Act funds cover the Caregiver Specialists' time. For more information about this innovative use of funds, contact the Aging Resources of Central Iowa:

<https://www.agingresources.com/>