The Caregiver Toolbox
Navigating the Healthcare Maze: The Hospital Setting

How to Watch for Someone's Best Interest in the Hospital

- Be an advocate!
- As a caregiver, you are often in the role of *spokesperson* for hospitalized person.
- You are in the best position to inform the hospital staff of the person's likes and dislikes.
- Often you are the one who communicates how he/she really feels and what he/she would want done.

Issues to Consider-The Hospital Schedule

Questions To Ask:

- Does the hospital use its own doctors (called hospitalists) who then report back to your doctor(s) or will your doctor(s) be visiting?
- When do the doctors usually visit patients on your floor?
- What are the hospital's visiting policies (may be more restricted during COVID)?
- What are the hospital's meal policies/choices and times of meals?
- When does the staff change shifts on that floor?
- What staff might be visiting the room? Can you request a visit by pastoral staff, therapy staff etc.?
- How often do they allow you to shower or change the linens?
- Do they expect you to call when you use the restroom?
- Is there WIFI and if so, how to access it?

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Issues to Consider: Personal Belongings?

- Think about what belongings to have with you or your family member. Valuable rings, jewelry and electronics might not be a good idea.
- Pay particular attention to a person's glasses, hearing aides and dentures.
- Label all belongings.
- Take pictures of belongings and ask if the hospital keeps an inventory list for patients.

Issues to Consider: Medications in the Hospital?

- *MAKE SURE* the hospital has an *updated* medications list so that the person can continue to take regular medications while there.
- Some medications, particularly pain medications can be prescribed in a manner, called PRN, which can allow the patient to have some flexibility to request pain or nausea relief.

Issues to Consider: Visitors and Students?

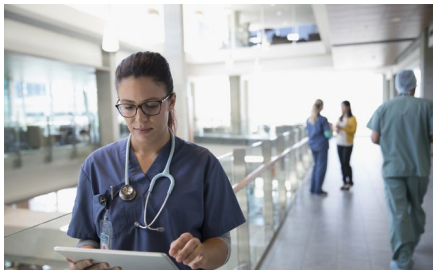
- You may wish to limit the number and frequency of visitors your loved one receives. Visitors sometimes do not understand how tiring their visits can be for someone who is ill.
- On the other hand, if your relative is lonesome and wants visitors, you may have to arrange for people to come and see the person in a manner that provides both pleasure and comfort.(Once COVID restrictions are relaxed).
- You can also express your preferences to limit the number of medical/health care students involved in the care of your loved one.

Your Right to Privacy

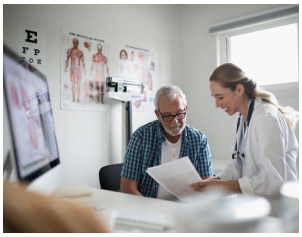
- *The Health Insurance Portability & Accountability Act (HIPAA) was passed in 1996.* It says that providers may not give information about your health situation to others ***without*** your authorization.
- A health care provider has to ask you about with whom they can discuss your protected health information. You will sign this form every time you get medical treatment.
- The hospital may give you a number or a code to give out to those you want to receive information about your status.
- However, the hospital MAY discuss information with your personal representative (legal guardian or power of attorney for health care) WITHOUT any additional authorizations.

Medicare Rights While in the Hospital

- Medicare pays by diagnosis-NOT how long you stay.
- You will be given a discharge date and you should ask for this information in writing.
- You may appeal this decision if you do not feel you are ready to go home by calling the number on the notice and telling them you want to appeal your discharge.
- There are two kinds of hospital stays under Medicare:
    - Observation Stay
    - Admission (You must be admitted to the hospital for 3 overnights to qualify for a skilled rehabilitation stay.)
- You are required to be given a written notice (called a ***MOON*** notice) to let you know what type of hospital stay to which you are being admitted(observation or full admittance).



The Role of the Discharge Planner



- "Discharge Planners" or "Case Managers" may be social workers or nurses.
- Their role is to create a transition plan for after the person leaves the hospital.
- Begins the day of hospital admission.
- Their role is vital to enable the patient to make a full recovery.
- Discharge Planners will:
    - Share information between the patient, caregiver and medical team.
    - Meet with patient, and caregiver to gather information.
    - Communicate with the medical team and the patient's insurance.
    - Arrange for medical equipment, community support services, home health care or transition to a care facility.

Information To Share With The Discharge Planner:

- How was the person was functioning prior to hospitalization – independent? – needing assistance? Having cognitive impairment?
- Who is involved in the person's care (if not independent)?
- Who is the primary caregiver(s) (family, friend, neighbor, paid caregiver)?
- Does the person have a case/care manager in the community? – What is their contact information.
- What assistance is being provided?
- What medical equipment is the person typically using? What is the person's living arrangement? (Alone, with family or others.)
- Are there accessibility concerns in the home? (Stairs, narrow doorways or halls)
- Are there unmet needs that would impact the person's recovery?
- Are there social needs such as housing, utility disconnections, food insecurity?
- Are there service needs? (meals, housekeeping, personal care, medication management)

Prior to Hospital Discharge to HOME--A Discharge Planner Will:

- Review medication list – reconcile between pre/post hospital lists, obtain new prescriptions.
- Discuss new medical equipment needs including oxygen, verify that items have been ordered or obtain prescriptions.
- Obtain training on any special care required such as wound dressings, feeding tubes, or catheter care.
- Verify that referrals have been made for home health care including nursing, physical/occupational/speech therapies, or hospice care, get the name of the home health agency that will be providing care.
- Make referrals for community supports to address unmet needs such as home-delivered meals, personal care aides, homemaking services, medical transportation.
- Determine what medical follow up appointments are needed.

Hospital Discharge to a Facility

- Person is medically stable for transition from acute to rehabilitative care
- Planning for continuity of care to aid person's recovery
- Requires clarification between care settings of the person's health status and capabilities
- Type of facility is determined by the person's care needs
    - Nursing Facility Rehabilitation
    - Rehabilitation Hospital (Subacute)
    - Short-term Respite Stay in Nursing Facility or Assisted Living
    - Long Term Nursing Facility or Assisted Living Placement

Facility/Healthcare Provider Selection:

Helpful Websites:

- www.ltc.age.ohio.gov Ohio Long-Term Care Guide
- www.medicare.gov (Nursing Home and Home Health Care Compare Tools)

Considerations in selecting a care facility:

- Specialized care needs ex. onsite dialysis, ventilator care, dementia care
- Quality indicators ex. recent state inspection report
- Tour and observe cleanliness, staff/resident interactions, residents' appearance, activities
- Convenience for frequent visitation

This information is provided by:
The National Family Caregiver Support Program

This is a nationally funded program operated in Central Ohio by the Central Ohio Area Agency on Aging (COAAA). It offers caregiver workshops and funds services designed to assist caregivers on a short term basis. The services include: information and assistance, counseling, respite, and other supplemental services.

Request a copy or download our other guide from our website www.coaaa.org:

- Central Ohio Older Adults Resource Guide
- The Caregiver Toolbox
- Central Ohio Long Term Care & Hospice Guide
- Central Ohio Housing & Home Repair Guide
- Central Ohio Private Homecare Guide
- Central Ohio Utility Guide
- Central Ohio Prescription Guide
- Central Ohio Transportation Guide
- Central Ohio Support Group Guide
- Central Ohio Respite Guide
- Central Ohio Moving & Transitions Guide
- Books, Videos, and Websites for Family Caregivers.
- Central Ohio Kinship Care Guide (New)
- Central Ohio Hiring Guide for In Home Caregivers (New)
- Central Ohio Pet Care Guide (New)

The COAAA also provides monthly Caregiver Support Groups & Information Sessions. For more information, call 1-800-589-7277 or visit our website.
Or in your county, call one of these agencies:

- **Delaware-**SourcePoint 740-363-6677
- **Fairfield-**Meals on Wheels Older of Fairfield County 740-681-5050
- **Fayette-**Community Action Commission of Fayette Co. 740-335-7282
- **Franklin-**Franklin Co. Office on Aging 614-525-6200
- **Licking-**Licking Co. Aging Program 740-345-0821 or 1-800-452-0097
- **Madison**-Madison Co. Senior Center 740-852-3001
- **Pickaway-**Pickaway County Senior Center 740-474-8831
- **Union-**Union County Senior Services 937-644-1010