The Family Caregiver Connection
Supporting Essential Care Partners as Patients Transition to Home

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Elder Care Transitions = Sinking of Titanic
My Mom’s Story

- 7 care transitions in 4.5 months after a fall/broken ankle
- Every care transition means starting from scratch
- No communication or coordination between facilities
- Lack of a comprehensive care plan
- Only source of up-to-date medication list = me
What is a Care Transition?

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>Hospital</td>
<td>Hospital</td>
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<tr>
<td>In-patient Rehab</td>
<td>In-patient Rehab</td>
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<tr>
<td>Assisted Living</td>
<td>Assisted Living</td>
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<tr>
<td>Nursing Home</td>
<td>Nursing Home</td>
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<tr>
<td>Hospice</td>
<td>Hospice</td>
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<tr>
<td>Home</td>
<td>Home</td>
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What are the components of a care transition?

- Change of physical location
- Medical record updates
- Medication changes/reconciliation
- Coordination of healthcare
- Coordination of social services
- Instructions/next steps
- New providers to educate
- Paperwork
- Family caregiver chaos
What makes elder care transitions unique?

- Frail condition of many elders
- Dementia & mobility issues
- Medication volume and complexity
- Living situations that don’t match care needs
- Fall risk
- Patient wishes vs family preferences/abilities
- Driven by what Medicare will cover
What Happens Today?

• Overall lack of knowledge about the needs of seniors with complex health conditions
• Unique aspects of elder care transitions are not factored into the equation
• Healthcare and social services operate in silos
• Patients and family caregivers have to figure out how to navigate the system on their own
• Discharge instructions and medication lists are written at a high literacy level and not user friendly
• Many tasks previously designated for nurses are now being handed to family caregivers
• Longterm care is not tech enabled – at all.
What Does NOT Happen Today?

• Communication
• Care planning
• Evaluation of family caregiver needs
• Training for patients/family caregivers
• Coordination of healthcare AND social services
• Accountability/reliable follow-up
• Treating the WHOLE patient
Result for Caregivers

• Absent from work trying to find resources & coordinate care
  ▫ Can’t find resources in their community
  ▫ Can’t afford resources they do find
  ▫ Can’t get access to medical records
• Not prepared or trained
• Neglect their own health and end up needing care
• Expend their own financial resources
• High likelihood their parent will make return trip to emergency dept and the process begins again...
What can the “system” do?

• Guide family toward services they may need and help coordinate them
• Provide clinical information in a way both patient and caregiver understand, i.e. plain language and language of choice
• Provide access to an aggregate medical record and assistance from a pharmacist to review & adjust medications
• Help put resources in place, starting with an on-call home health nurse
Tools to Support the Circle of Care

Geri Lynn Baumblatt, MA
@GeriLynn
Disclosures

Advisor, Roobrik

Advisor, Helpsy Health

Beta Tester, Atlas of Caregiving CareMap app

Consultant, Active Daily Living
Concerns

- Safely providing care
- Skills
- Understanding
- Finances
What they don’t know…

- Social Isolation
- Family strife
- Injuries to self
- Care coordination
- Their job/employment
- Their health
Including Informal Caregivers of Elderly in Discharge Process Reduces Readmission Risk

25% reduced risk of readmit within 90 days

24% reduced risk of readmit within 180 days

https://atlascaremap.org

@atlasofcare
The COPD caregiver's toolkit:
Information, advice and tools for anyone caring for a person with COPD
...designed with and for people like you

1. How do I help the person I'm caring for manage COPD?
2. What should I know about managing a home for someone living with COPD?
3. How do I prepare for a visit to the doctor?
4. How do I help after a COPD flare-up (exacerbation) or hospital stay?
5. How do I take care of myself while managing someone else's care?

Some sections might apply to you more than others, so we designed this toolkit so you can start from anywhere.
How do I help the person I’m caring for manage COPD?

1. How do I help the person I’m caring for manage COPD?

Tips for managing in extreme weather

Managing in warm weather

- During the summer, try to avoid exposure to sun and warm air. When heat and humidity increase, it is best to stay active indoors and in an air-conditioned environment.
- Keep cool by staying indoors in the early morning or late afternoon.
- Use fans or air conditioning to reduce indoor temperature.
- Drink plenty of fluids to stay hydrated.
- Take breaks in shaded areas or seek air conditioning when outside.
- Check on older adults or those with underlying health conditions who may be at higher risk.

Managing in cold weather

- Cold, dry air can worsen COPD symptoms. During fall and winter, respiratory viruses like the flu and colds spread more easily.
- Stay warm and dry by wearing multiple layers of clothing.
- Use a humidifier or vaporizer to add moisture to the air in your home.
- Avoid being around sick people.
- Practice good hand hygiene to reduce the spread of viruses.
- Get seasonal flu vaccines to prevent flu illness.

What questions should I be asking the doctor?

Preparing questions ahead of time will help you make the most of your next appointment. Bring your list of questions to your next appointment.

General case questions

- Discuss with your doctor what to do in a non-emergency. For example, someone might want to be notified at the first sign of an acute respiratory problem.
- Ask for referrals for local resources to help you care for the person you are caring for. (For example: www.lungchicago.org)
- If the person you care for has other medical conditions—such as diabetes, obesity, osteoporosis, heart disease or other not listed here—ask the doctor about these conditions should be included in the care you give.
- Talk about flu and pneumonia vaccines for the person you are caring for.
- Offer family members to stay in touch with the person you care for.
- Ask the doctor about how to set up a medication plan for the person you are caring for.
- Ask if pulmonary rehabilitation is a good fit for the person you are caring for and what options are available.
- Ask if oxygen therapy will help.
- Ask your doctor about indoor and outdoor triggers and any avoidance tips.

Keep track of your conversation here:

Date:

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RESPIRATORY HEALTH ASSOCIATION | CAREGIVER TOOLKIT 22
I THINK YOU'RE A GREAT FRIEND TOO.
Example Interaction
Avatar = human + software

@careDOTcoach
The Avatar Solution
The best of human & software intelligence

↑ wellness
↑ self-management
↓ ED visits / admissions
↓ readmissions

↑ value-based care $$$
↑ patient satisfaction
↓ delirium
↓ falls

Family Portal
Provider Portal
24x7 personalized support

Care Avatar
Health Advocates
Clinical Algorithms

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ROI from Avoiding Readmission
De-identified patient data shown

Email + phone alert triggered by contextual response:

**Prevented Readmission**

$13,000 cost avoidance
by informing clinical team to adjust medications
• Passively tracks day-to-day activity of the care recipient in their living space
• Activity and inactivity compared against defined criteria and daily living patterns
• If activity falls outside normal patterns, caregivers receive alerts
CAPTURES INFORMATION
- Motion
- Door status
- Bed/Chair occupied
- Pill box access
- Stove left on

ANALYZES DATA
and compares to selected safety criteria

Caregiver Installs Devices
Caregivers Select Alert & Notification Criteria
SafeinHome
Caregivers Receive Actionable Information

ALERTS
Immediate Attention

TREND ANALYSIS
Identifies changes

OBSERVATION on Demand
Tracking of multiple days activity

Table:

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<thead>
<tr>
<th></th>
<th>Thu 9/3</th>
<th>Fri 9/4</th>
<th>Sat 9/5</th>
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<tbody>
<tr>
<td>Tv</td>
<td>11</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Bathroom Visits - Daytime Hours</td>
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71% of caregivers interested in technology

... only 7% use it

Why Not?

- Don’t know which tech to use
- No time to learn new tech
- Clinicians need to suggest friendly tech

AARP 2016
Empowering Patients & Caregivers After Discharge
In an ideal world – patients and caregivers would leave any episode of care understanding everything they need to know to *get better, stay well*, at their *highest level of function* and have access to all the tools they need for success.
Technology to Maintain Connection

- Keep patient at the center
- Drive patients to the right actions
- Include family and caregivers
- Personalized
- Delivers consistent message in reliable manner
- Delivers results for providers
Extending Reach
EmmiTransition®

- Proactive, scalable and automated call campaigns
- Helps people transition from hospital-to-home
- Reinforces key messages to individuals and family
- Tracks and documents activity and recovery
- Corresponding EmmiEngage® programs

Engages
with Emmi’s empathetic voice

Collects
vital information from users

Provides
daily reports on recovery status

Notifies
Staff of people at-risk of readmission
Unique Approach – Understands People

Built on *Behavioral & Educational Science*
- Triggers
- Habits
- Motivators
- Positive Psychology
- Action Planning

*Human Centered* Design
- Intuitive
- Non-disruptive
- Empathetic
- Normalize & De-stigmatize
- Reduce Anxiety
If your doctor’s office can’t get you in soon, make sure they know you were just in the hospital and were told you have heart failure.
Heart Failure Harry – 45 days of connection

Transportation to follow-up appointment?