

Understanding and Negotiating the Healthcare System:

Practical Information for Older Adults

presented by

**Piedmont Hospital Sixty Plus Older Adult Services
and Visiting Nurse Hospice Atlanta**

In partnership with The Atlanta Regional Commission,
Area Agency on Aging and the Healthy Aging Coalition

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Introduction

Your visit to the Emergency Department or your stay in the hospital can be both challenging and confusing. The hospital experience, like most of healthcare, continues to change and in many ways is no longer like it was in years past. Piedmont Hospital wants to help you know what to expect when you come to the hospital and to understand how we provide your care. This information will answer some of the most common questions patients have. If there is anything you do not understand, please ask your nurse or doctor.

COMMON QUESTIONS INCLUDE:

How long will I be in the hospital?

This will depend upon how sick you are and how quickly you begin to recover. Your doctor knows that people recover quicker when they are up and moving around. Based on your medical condition and other factors, Medicare, Medicaid or other insurance providers will say what they will pay for. Your medical team wants to assure a safe care plan for each patient. This plan will include good instructions on how to care for yourself when you leave the hospital and will be based on what will work best for you and your family.



You may need to go to another kind of care facility for rehabilitation to help your recovery. If you are going home, the doctor may provide home medical visits through a home health agency to make sure recovery is going well.

What should I bring to the hospital with me?

Bring your personal health record.

1. All medicine bottles and eye and ear drops (both prescription and over the counter) or a current list of your medicines including: when, why and how you take them.
2. Health insurance cards and identification.
3. Contact information for important friends and family.
4. A list of your current doctors with their phone numbers.
5. A list of your prior illnesses, visits to the hospital and surgeries with the dates.
6. A copy of your Living Will and Durable Powers of Attorney for Healthcare called the Georgia Advance Directive for Healthcare (*see page 4*).

What is a Hospitalist and how will the Hospitalist impact my care at the hospital?

A hospitalist is an in-hospital doctor who works with your personal doctor to ensure that you receive good care during your hospital stay and when you leave the hospital. The hospitalists work as a team with you, the nurses and other care providers. This medical team is dedicated to your day-to-day care in the hospital and will be sure you leave with a coordinated and safe discharge plan when you leave the hospital.

Who are Discharge Planners/Case Managers?

These terms refer to the person (usually a social worker or nurse) who is part of your medical team and will work closely with you and your family to coordinate your home care and health needs after you leave the hospital. Expect your medical team (doctors, nurses and discharge planner) to begin planning for your discharge on the first day of your stay.

Discharge plans may include:

- home health or other in-home services
- home equipment such as a hospital bed or walker
- names/numbers of people to contact with questions/concerns
- teaching and follow-up instructions to best manage your illness
- how and why you need to take your medicine

Ask for the name and number of your case manager at the nurses' station. The sooner your discharge planning starts, the more time you and the

medical team will have to make the best decisions about your care needs and resources to help at home. The discharge planner can meet with you and your family either together or separately. This time together is helpful so everyone has a chance to talk about any concerns or issues about the plan and agree upon a common goal or set of goals.

When should I schedule a follow-up visit with my doctor?

Normally, you will call to schedule any follow-up visit with your doctor(s) before you leave the hospital and should be within 5-7 days of discharge. Let your medical team know if there will be any problem getting to the doctor or any payment concerns.

What is medication reconciliation and why is it so important?

One of the main reasons patients come back into the hospital is problems with medicines.

Medication reconciliation is the coordination of the medications you take before, during and after your stay at the hospital. Your medical team must know what medicines (prescription and over-the-counter) you were taking before coming to the hospital. The medical team will make sure your drugs are right for your illness both while you are in the hospital and when you go home. Your medical team depends on you or a family member to make sure they have the right information.

- Bring the actual medicine bottles (both prescription and over-the-counter) with you to the hospital or bring a current list of the medications you take including how you take them. Be sure to bring any vitamins, herbs and other items you take for your health.
- Ask your doctor any questions about your medicines before you leave the hospital (see *Discharge Checklist on page 6*).

What are Home Health Services and how can they help me?

Because of shorter hospital stays, and your medical condition, you may benefit from receiving home health services. Home health services may include nursing, physical therapy, occupational therapy, speech therapy, social work and personal care, like bathing and grooming. Ask your doctor about home health services and if they would be helpful to your care. If you and your doctor think it will help, a home health person will talk with you and arrange for the services you need. Typically, you will receive a home health visit two or three times each week for several weeks. The number of visits you will receive will always be based on your medical condition. Home health services must be ordered by your doctor and your illness must meet home health guidelines in order for Medicare and other insurance providers to pay for them.

What is the difference between a Private Duty or In-Home Care and Home Health Service?

Many patients do not understand the difference between skilled home health services and unskilled in-home or unskilled private duty care that provides a range of services including bathing, grooming, dressing, cooking, companionship, shopping and light housekeeping. Many patients may need the service daily or just once or twice a week. Medicare does not pay for this service. Most often this care is paid for by the patient although long-term insurance and some limited programs through Medicaid may be an option.

WHEN SHOULD I CALL 911?

Emergencies require immediate medical attention either by calling 911 or going to the Emergency Room (ER). Difficulty breathing, loss of consciousness or chest pain are emergencies. Urgent problems after doctor office hours are also emergencies. If in any doubt be cautious and call 911 or ask someone to bring you to the ER.

Urgent problems need to be seen by a doctor that day but are not life threatening. These problems may include: nausea or vomiting that continues, urinary tract infections, irritants in the eye, cuts requiring stitches or a reaction to a medication that is not life threatening.

Routine problems may include: getting your medicines refilled and minor illnesses such as sore throat, cold or a rash. Routine problems are best addressed by your primary doctor. A call to the doctor's office may be all that is necessary.

TIPS FOR THE ER VISIT

- If possible have someone come with you.
- Be prepared to wait. It takes time to run tests and get x-ray results.
- Do not eat or drink anything without asking.
- Bring as much information as you can when you come in (*see list of what to bring to the hospital*).
- If you are sent home (discharged and not admitted to the hospital), be sure you understand what you need to do to feel better. You will get what is called a discharge plan. Ask questions when you are not sure what the plan means.
- Know the Emergency Room phone number to call with questions once you get home.
- Schedule a follow-up visit with your doctor as soon as possible after the Emergency Room visit. Tell the doctor's office when you call that you have been to the ER and why.

WHAT SHOULD I KNOW ABOUT END OF LIFE CARE?

When everything has been done to treat your illness and you may only have a short time to live, the first concern is to decide how to receive the best care and comfort possible. This is a topic that everyone should be sure to discuss with those close to them before a health crisis happens. It is important to have your wishes known by completing an Advanced Directive for Healthcare.

This will make sure the right decisions are made. Care choices to be discussed with your family and the medical team include:

- **Allow Natural Death Order** (also known as AND) means that no life-saving measures will be taken if the heart stops beating or breathing stops. The focus is on allowing the patient to be comfortable and free of pain.
- **Palliative Care** is usually introduced during the early stages of a serious or terminal illness and will focus on comfort and quality of life when it is unlikely that a patient's illness will continue to benefit from treatments. Palliative care often leads into hospice care, depending upon the condition of the patient and individual and family wishes.
- **Hospice Care** is focused on quality of life rather than length of life. Reducing pain and other distressing symptoms are key to hospice care. Cancer, heart disease, lung disease or late-stage dementia can become appropriate for hospice care. Hospice Care can be provided at home or in a hospice facility. The service also provides care and support for family members during this time.

What are Advanced Directives for Healthcare?

"Advanced Directives" is the general term given to documents such as Living Wills and Durable Powers of Attorney for Healthcare. They allow you to make your own healthcare choices even if you become so ill that you cannot speak for yourself. You will name a trusted person – a family

member or friend – who will agree to make sure your healthcare wishes are honored. When patients come into the hospital, the staff must ask if you have any type of advance directive for healthcare. You will be encouraged to complete this document if you have not already done so. In Georgia, the Living Will and the Power of Attorney for Healthcare has been combined into one document called the Georgia Advance Directive for Healthcare. Keep the original copy in your own files and give copies to close family and friends who are likely to be there for you. Also give copies to your doctors and bring a copy to the hospital. You can make changes to this document whenever you wish.

ADVICE FOR THE FAMILY

What is the role of the family caregiver?

Family caregivers are important to the patient's care because they give the patient needed comfort and often serve as the patient's voice. This role is especially important when the patient has memory loss. It is helpful for families to appoint a primary family member who will be responsible for getting needed information both to and from the medical team and communicating with other family members and friends.

- Be prepared to stay in the hospital close to the patient when there is memory loss or confusion. If you cannot be there, you may need to hire someone to be with your loved one. The hospital can provide a list of names or private duty agencies.
- Provide information to the medical team about the patient's abilities to manage and get around before coming into the hospital. Is there any memory loss, episodes of falls or other on-going concerns? Is the patient showing signs of a sudden change in behavior or ability to manage?
- Help to make decisions early in the hospital stay for the best discharge plan.
- Be familiar with any services to be provided after discharge including the name, phone number, start date/time and who to call if there is any delay in services.
- Know what medical equipment the patient will need at home, the name/phone number of the medical supply company and when the equipment is to be delivered.
- Help the patient promptly schedule follow-up appointments with doctor(s) within 5-7 days after leaving the hospital.
- Know the “red flag” (signs and symptoms) of the patient's medical condition and when to notify the doctor or what to do in an emergency.
- Talk with others about helping with the patient's needs and know how they will help.
- Help the patient meet his/her goals for recovery.
- Let the health team know if there are concerns about finances.

Most important - be sure to take care of yourself. Ask for help when needed!

DISCHARGE CHECKLIST FOR PATIENTS AND CAREGIVERS

Adapted from CMS Pub. No. 11376 – June 2008

This checklist is provided for the patient and the family caregiver. It is essential to the patient's recovery that the patient and caregiver understand all discharge instructions and what is expected.

Follow-up care:

- Ask where you will get care after you go home. Ask your care providers to explain options and be sure they understand your wishes.
- Make a list of doctors with contact information to call with questions or problems.
- Make all follow-up medical appointments prior to leaving the hospital.
- Schedule any tests.

Your health condition:

- What are the “red flags” (signs and symptoms) of the illness?
- What should you do if you have these symptoms?
- When should you seek emergency care?
- When should you seek urgent care?
- When should you seek routine care?

Medication Instructions:

- Have you informed your care provider about every medicine, including over-the-counter, that were taken before, during and after your hospital stay?
- Do you understand why you are taking each medicine?
- Are you aware of the possible side effects?
- Do you know how to take your medicines?
- Do you know who to call with questions?
- Do you know where you will fill and whether or not you can pay for your prescriptions?

Medical equipment for your home:

- Do you know what medical equipment you may need?
- Who will deliver the equipment?
- When will it be delivered?

- Will the equipment require training, and if so, who will provide it?
- Who to call if you have problems with the equipment?

For family members or other caregivers:

- Do you understand what help the patient will need from you and others?
- Have the discharge instructions been explained to you? Do you understand them?
- Are you able to provide the help needed by the patient?
- If you are not available, what are the other options?
- Do you know about resources for you – the caregiver? If not, ask.
- Have you received the necessary instructions for any of the tasks you will need to carry out? If not, is there a plan in place for you to receive this instruction?

Written discharge instructions:

Have the written discharge instructions been explained to you, including:

- Red flag signs and symptoms of the condition (what to look out for)?
- Who to contact with questions/concerns?
- When and where to follow up?
- The medicines you will take following discharge?
- Instructions for medical equipment?
- Contact information for home health care or other after care services?
- When you should seek emergency care?
- Where will you keep your discharge information?
- Bring written discharge information to any follow-up medical visit.

This information is provided to the Atlanta Community through The Care Transition Demonstration Project and the Healthy Aging Coalition.

THE CARE TRANSITION PROJECT PARTNERS INCLUDE:

Visiting Nurse/Hospice Atlanta

A full service, non profit home healthcare organization offering a full spectrum of home and hospice services to adult and pediatric patients.

www.vnhs.org | 770-454-0900

Atlanta Regional Commission, Area Agency on Aging

As the Area Agency on Aging (AAA), the Atlanta Regional Commission (ARC) plans and provides comprehensive services to address the needs of the region's older population

www.agewiseconnection.com | 404-463-3333

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