

AN E-BOOK BY

McKnights

BEYOND DISCHARGE: SUPPORTING CARE TRANSITIONS AT HOME

Reducing readmissions in older adults with complex chronic conditions

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ComForCare HOME CARE



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In the hospital, someone is always there. A nurse checks vitals at 3 a.m. A monitor beeps if something's wrong. Medications arrive on schedule. Then the patient goes home — whether from the hospital, a skilled nursing facility or a rehab center — and that round-the-clock support stops, often literally, overnight.

Recovery at home usually means piling new instructions and medications on top of conditions the patient is already managing. Nationally, 93% of adults 65 and older live with at least one chronic condition; nearly 79% live with two or more. The consequences of not managing such conditions are well-documented. For nearly 1 in 6 Medicare hospital stays, the patient is back within 30 days, the Medicare Payment Advisory Commission has reported.

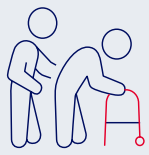
WHERE READMISSION GAPS BEGIN

Avoidable readmissions don't necessarily begin with one dramatic failure. They can begin with small gaps in the transition plan. Missed medication doses. Confusion about discharge instructions. Skipped follow-up appointments. Each one chips away at what every care team is working toward: safer transitions and quality outcomes.

Discharge also can mean managing a new or worsening condition.

"If you're talking about something like congestive heart failure or COPD, now there are new things you need to track," said Jake Baker, BSN, RN, clinical and compliance director, ComForCare Home Care. "Maybe the patient wasn't weighing themself every day, and they didn't care if they went up a pound or two. But now they do. Those are the things to look out for."

Patients are also juggling the newness of it all — an unfamiliar condition, a new medication regimen, instructions they've never followed before — all largely on their own. Even basic daily activities suddenly can become



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Source: MedPAC

a struggle: eating, bathing, toileting or getting out of a bed or chair. And there's often another layer to returning home from a care facility that most people don't consider: feelings of anxiety or depression.

MAKING DISCHARGE ORDERS WORK AT HOME

Transitioning from the hospital, skilled nursing or rehab care to home isn't about duplicating clinical health services; it's about making the clinical plan workable at home. That's where nonmedical home care earns its place as a vital part of the interdisciplinary team: reinforcing the discharge plan in the first weeks at home and complementing the work of home health nurses, physical therapists and physicians. ComForCare's transitional care services put that into practice — a blend of clinical evaluation and nonmedical caregiver support, with the specific mix shaped by each state's licensing requirements.

"It's not just a caregiver showing up without knowing what's going on with the patient," Baker said. "That's part of the process we teach every agency."

A nurse evaluation follows — a true head-to-toe clinical visit, not a check-in. It establishes a baseline; any change from it is the caregiver's signal to loop in the medical team. Medication reconciliation happens during that same evaluation — comparing the discharge list against what's actually in the home.

"Sometimes what's on that list isn't what you see in the home, or there's a medication the patient says, 'I don't take that anymore,'" Baker said.

Nonmedical caregivers don't manage medications directly, but they're often the ones to first see gaps between what a patient is taking and what they should be taking — and flag those gaps to the care team.

A home safety assessment identifies loose handrails, throw rugs, exposed cords, oxygen-related fire risk and tripping hazards. It works: A 2023 Cochrane review found that home hazard reduction can cut the rate of falls by about a quarter, and by more than a third among older adults who have already fallen. Catching these dangers before they cause falls, or worse, matters most in those first days home.

> Our caregivers can be the eyes and ears in between each of those visits.
>
> — JAKE BAKER, BSN, RN, COMFORCARE HOME CARE

Discharge paperwork can run 10 to 20 pages. Caregivers help patients turn those written instructions into day-to-day tasks, especially when limited vision or medical literacy makes the paperwork harder to navigate.

There's also the matter of follow-up: Does the patient see the hospital's physician or their own primary care doctor, and how do they get an appointment? Caregivers help close that loop.

'THE EYES AND EARS'

Skilled nursing and home health visits are essential, but they're often brief — an hour, a few times a week. In the days between, someone still needs to be paying attention — which is where nonmedical caregivers come in.

"Our caregivers can be the eyes and ears in between each of those visits," Baker explained.

A caregiver notices when a heart failure patient has suddenly gained several pounds overnight. They notice when a normally sharp patient seems confused, or when medication isn't being taken as scheduled. None of this requires a clinical judgment call. It requires someone paying attention and knowing who to call.

That role takes training. As part of its transitional care services, ComForCare recommends caregivers complete ori-

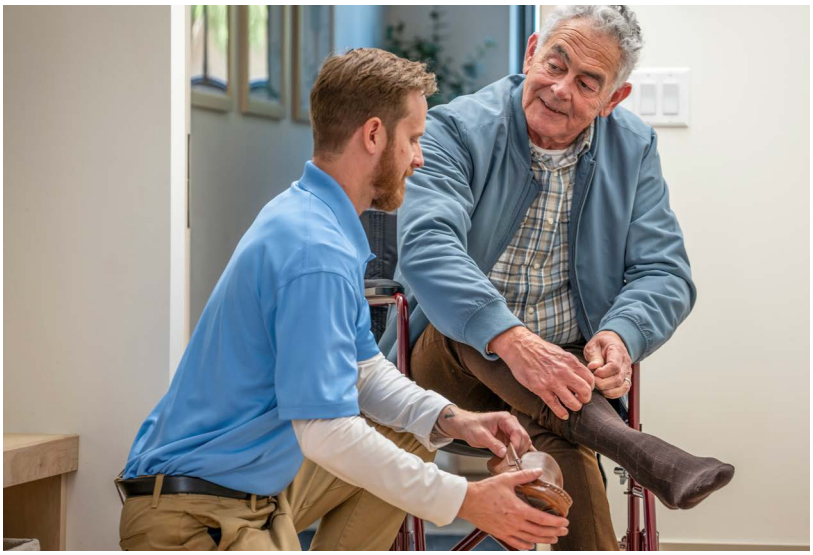


Photo provided by ComForCare

Caregivers can help ease the transition of older adults from the hospital to home — and support efforts to reduce avoidable readmissions.

entation and, in some states, skills-competency evaluation before ever entering a patient's home — the foundation for knowing what to watch for, and when to raise a concern.

Relying only on scheduled reassessments, Baker noted, "leaves too much on the table" — too many moments when early intervention could have made a difference. For physicians and case managers, closing that gap doesn't mean added responsibility; it means another trained set of eyes watching the space between visits and sharing what may need clinical attention.

> The collaboration is really what makes the process work.
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That same presence matters for families, too. A son or daughter juggling a parent's medications, appointments and daily needs — on top of their own job and household — benefits when someone else is also watching and reporting back. Nonmedical home care complements family caregivers, offering support and instilling confidence that they're not managing a parent's recovery alone.

FROM RECOGNITION TO ACTION

What a nonmedical caregiver can do in a patient's home depends on the state and the caregiver's scope. Most nonmedical caregivers can offer medication reminders and sometimes assistance, like opening a bottle.

ComForCare also equips patients, families and caregivers with condition-specific tools — often organized as green, yellow and red signals, per the American Heart Association — to monitor changes and know when it's time to call the care team versus 911. A heart failure patient who gains more than 2 to 3 pounds in a day typically moves into the yellow (or warning) zone, and everyone knows it's time to call the nurse rather than wait. COPD works the same way. Under the American Lung Association's action plan, being more short of breath, tired or coughing more than usual is a yellow-zone change. Severe shortness of breath even at rest is red; call 911.

Much of the rest is less clinical but no less important: keeping a home free of clutter, helping with daily tasks like dressing or bathing, making sure a patient can rest comfortably.

Nonmedical caregivers can help with the following complex chronic conditions



Heart failure and other cardiac events: Support with weight checks, sodium-restricted diets and follow-up appointments



Chronic lung conditions (like COPD or pneumonia): Reminders for inhalers or nebulizers, energy-conserving techniques, and help getting to pulmonary rehab



Stroke or neurological events: Assistance with mobility, activities of daily living, and practicing therapy exercises between visits



Joint replacement and other surgeries: Safe transfers, walking assistance and encouragement to follow prescribed rehabilitation plans

Source: ComForCare

CLOSING THE CIRCLE OF CARE

Nonmedical caregivers aren't a substitute for clinical care; they complement it, supporting the safety and consistency of day-to-day routines and filling the hours between clinical visits with attention and communication. Making that work, Baker said, comes down to two things above all: early intervention and a care team that's talking to each other.

"The collaboration is really what makes the process work," he said.

When physicians, case managers, home health providers, families and trained caregivers stay connected, patients recover more safely — and lessen the risks of hospital readmission. ■

To learn more, explore these ComForCare resources:

Reducing Hospital Readmissions

Transitions of Care