Moving from Place to Place Northern Maine Edition: A Consumer Navigation Guide for Seniors Involved in Health Care Transitions

University of Maine Center on Aging

Eastern Area Agency on Aging

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Moving from Place to Place

A Consumer Navigation Guide for Seniors Involved in Health Care Transitions

Northern Maine Edition
(Penobscot, Washington, Hancock, Aroostook, and Piscataquis Counties)
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Introduction

As a senior or a caregiver of a senior, moving from place to place to help meet care needs can be difficult. This guide was created to help serve as a resource when you are making transitions. Use the guide as a tool to help you think about many important aspects of transitions from hospitals, nursing homes, assisted living facilities, and community based living. There are many health care and community based professionals who can help you with transitions.

We share this guide with tips and ideas on how to approach transitions safely and smoothly. A thoughtful group of organizations including staff from the University of Maine Center on Aging, the Maine Chapter of the Alzheimer Association, the Aroostook Agency on Aging, and the Regional Medical Center at Lubec helped the Eastern Area Agency on Aging in developing this guide. We hope you find this guide useful. This guide was made possible by a generous grant from the Maine Health Access Foundation.

Section I - Moving from a Hospital to Your Home

Step 1 - Know What Type of Help You Need

If you are in a hospital or nursing home, your social worker or discharge planner can help you determine what type of help you need to look for. The types of help available are as follows:

Homemaker Services: Assist with grocery shopping, housekeeping, or laundry

Chore Services: Assist with mowing the lawn, raking leaves, or simple home repairs

Personal Support Services: Assist with bathing, dressing, eating and other activities

Home Health Aide: Assist with bathing, dressing, and doing some exercises

Skilled Nursing: Registered Nurse to help with your medical needs

Rehabilitative Services: Such as Physical, Occupational or Speech Therapy, assist with getting back your ability to do certain activities.

Homemaker Services: You can pay for these services through Maine’s Homemaker Program or by private pay. Individuals and various agencies offer these services. Be sure to be clear about what type of help you need. For example, a housekeeping service may meet your needs. You can expect to pay 20% of the hourly rate for services provided by Maine’s Homemaker program or $15 to $18 per hour if you privately hire.

Chore Services:
These services can be paid for by some area agencies on aging or community based programs or you can private pay. Typically, these services are offered by individuals, private companies and local agencies. It is suggested that you check references carefully and be sure you know what the service will cost in advance. Costs vary, depending upon the job to be done. Expect to pay between $10 and $50 per hour. Some services have no cost associated with them as they are provided by community volunteer organizations.
Step 2 - Eligibility
Most programs have requirements for eligibility. Eligibility can include both medical and financial guidelines. This means that you need to have certain medical needs that the program helps you get. Many programs also have financial income and asset limits. Some require that you have MaineCare or Medicare coverage to receive the services.

If you are unsure about what type of service you need, talk with your doctor and the hospital discharge planner. They will be able to give you an idea about the type of service you will need.

Step 4 - Determine How You will be Paying for the Services

Medicare - only pays for home services that are needed after an immediate illness or injury. How much help you can get depends on your needs and what the rules allow. Medicare will not provide home care services over a long period of time.

MaineCare - only pays for home services that are needed after an immediate illness or injury. MaineCare may also pay for services in your home, your community or a long term care facility. Mainecare may pay for long term care help at home.

Veteran's Benefits - depends on what your benefits are as to how much it will cover for home care. Check with your local VA office for specific details.

Long Term Care Insurance - review your specific policy for types of services covered and how much service will be covered. There may also be certain requirements about how much help you need to get the insurance to pay for that help.

Personal Support/Care Services:
You can pay for these services through state funded programs, various MaineCare programs and some long term care insurances. These services are offered by individuals, registered personal care agencies or through traditional home care agencies. Check references carefully and be sure there is staffing in your area. State funded programs require that you help pay the cost while MaineCare charges a small monthly fee. Fees for registered personal care will vary, depending upon the agency, but in general expect to pay from $15 to $18 per hour for private pay.

Skilled Nursing Services:
These services can be paid through Medicare, MaineCare, your long term care insurance or by private pay. Skilled Nursing services are offered by licensed agencies, physician offices and nursing facilities. Costs are generally between $65 and $100 per visit by a registered nurse in your home and billed to your insurance.

Rehabilitative Services:
Are paid through Medicare, MaineCare, long term care insurance and by private pay. Outpatient facilities or licensed agencies offer rehabilitative services. The costs vary depending upon the type of service required and where you receive the services. Generally over $100 per visit.

Average range of service costs are as of August 2006
Medicare Certified Hospice Program - The hospice program meets the Medicare eligibility requirements to provide the Medicare hospice benefit.

Step 6 - Get the Services Scheduled
Call a home health agency, provider, or the person that will be providing your services and schedule the first visit. At the first visit, many questions will be asked about your needs and a plan will be developed together so you know what days/times you will be getting help. Most agencies do their best to meet your schedule needs. Often agencies may not have staff available to provide visits at all times of the day and on weekends/holidays. Having a back up plan is very important in case your services are not available on any particular day or if your worker can not get to your home due to weather or illness.

Step 7 - Document the Services you Receive
Keep a record of all the services you receive, including how much time the worker spent at your home, who the worker is, and what type of care you received. This gives you something to compare the information on the bill with when you receive it.

Note:
If you are using long term care insurance, Medicare or MaineCare to pay for the services, you can use an agency qualified to provide those services. Talk with the provider before you start to use the services to see if they are qualified to provide the services.

Home health agencies and other health care providers often also meet strict standards for operation under accrediting organizations like the Joint Commission of Accredidation of Hospitals and Home Care Organizations. These agencies may have higher quality standards in place.
Section II - Moving from a Hospital to a Nursing Home

If you are moving to a nursing home from the hospital, here are the steps you and or your caregiver need to take.

Step 1 - Know Your Needs
When moving from the hospital, there are many questions that you will be asked. These questions will help determine whether you need to go to a nursing home or to some other type of facility. Take some time to think about these questions with your caregiver or another trusted person.

Some areas to consider are:

- How will you take a bath and get dressed?
- How will you walk? Will you need a wheelchair, cane, or walker to move around?
- Do you need help to get in and out of a chair or the bathtub?
- What household tasks such as laundry, grocery shopping or meal preparation need to be done every day?
- Will you need help getting stronger after your stay in the hospital?
- Will you need help managing your medical treatments and medicines?

Knowing how much help that you or your caregiver need will help answer questions you will be asked as you get ready to leave the hospital. The discharge planner, nurse or social worker will help you explore the types of services you may need currently as well as services that you may need in the long term.

Your doctor, social worker and nurse can also be there to help answer the questions. It is important to write this information down, so that you have it as you move ahead.

Step 2 - Determine How You are Going to Pay for It.

If you will be paying for the nursing home care yourself at an average monthly cost of $5500, go to Step 3. If you need help paying for nursing home care, you need to complete a MaineCare Long Term Care application. These applications are available at your local Department of Health and Human Services (DHHS) office or contact your local area agency on aging for an application. If you need help filling out the application, your local area agency on aging or DHHS office can help you.
A Consumer Navigation Guide for Seniors Involved in Health Care Transitions

Step 3 - Get an Assessment
Completed by Goold Health Systems

The assessment tells you if you medically need the services of a nursing home. The hospital will arrange for this assessment as you get closer to moving to the nursing homes.

Goold Health Systems is contracted by the DHHS Office of Elder Services to complete the assessment. After the appointment is scheduled, a registered nurse will visit you and complete a list of questions. The nurse will ask you questions about your medical condition and what has happened to you recently to get you to the hospital, questions about the type and amount of help you received while in the hospital and how much help you need going forward. The nurse will review your record at the hospital. Refer to your answers from Step 1.

Address the completed application as follows:

Department of Health and Human Services
Office of Integrated Access and Support
Attention: Long Term Care MaineCare

Mail to the appropriate office location listed below:

In Bangor: 396 Griffin Road
Bangor, ME  04401

In Calais: 392 South Street
Calais, ME  04619

In Caribou: 14 Access Highway
Caribou, ME  04736

In Ellsworth: 17 Eastward Lane
Ellsworth, ME  04605

In Fort Kent: 137 Market Street
Fort Kent, ME  04743

In Houlton: 11 High St.
Houlton, ME  04730

In Machias: 13 Prescott Drive
Machias, ME  04654

Tips for the assessment process:

• If you are in the hospital, a social worker or nurse can be of assistance during the assessment.
• Answer the questions honestly. Do not overestimate or underestimate your abilities to care for yourself.
• Make sure that a family member or friend participates in the assessment process. At times of stress, you often miss important information and it is good to have a second person to hear what the nurse has to share for information.
• Have the following information available for the nurse if you need financial assistance in paying for the nursing home services:
  • Medicare card
  • MaineCare card (if you have one)
  • Social Security card
  • Long term care or other health insurance policy cards
  • Your monthly income (dollar amount)
  • A list of your assets and associated dollar values (include savings, checking account amounts, pensions, CDs, or any assets that can be made into cash)
Moving From Place to Place

Step 4 - Find a Nursing Home
After the assessment is completed, the nurse will explain what services you can get and where you can get these services. If you are eligible for care in a nursing home, it is time to find a nursing home. If you are in a hospital or other facility, the social worker may be able to help you find a nursing home that fits your needs.

Keep in mind that entering a nursing home is a process and may take up to 45 days if you have requested financial help from MaineCare.

Often, patients leaving the hospital are admitted to a Skilled Nursing Facility under Medicare coverage for a period of rehabilitation before transfer to long term nursing care (see Section III on page 11). In many cases, hospitals have such units as do most nursing homes, thus providing at least part of the solution as to where the senior can stay while awaiting long term care placement.

How do reports issued by state and watchdog organizations rate and rank the home you are considering? Check Medicare’s Nursing Home Comparison Website http://www.medicare.gov/NHCompare/Home.asp and the resources listed below for such information. The effort that may be incurred could be offset by the aggravation of later moving a loved one from a poor quality home.

Step 5 - Contact the Nursing Home and Arrange for a Visit with Your Family or Friends
This will help you know if it is a good fit for you before you move. Use the nursing home check list in Step 4 to help you compare facilities.

Step 6 - Begin the Moving Process
After you have been given an invitation to live at the nursing home, arrange to move your personal clothing, furniture, etc. to the facility. Complete any admission paperwork required - a social worker will help with that process.

Step 7 - Change Your Address
Address change packets are available at your local post office.

Step 8 - Get Help with Your Previous Home or Apartment
This could include selling your property, ending a lease, selling furniture etc. It is important to know that if you get financial help to pay for your nursing home arrangement, there are laws called estate recovery that may be applicable. Speak with a lawyer at Legal Services for the Elderly or your personal lawyer to see what may be applicable to you.

Step 9 - Organize Your Important Papers Needed for the Move
Make sure to bring important papers with you upon admission including:

• Advanced Directives or Living Wills
• Health insurance cards including MaineCare, Medicare and/or long term care
• Prescription drug plan card(s)
• Signed discharge orders from your doctor
• Forms required of the specific nursing home - you will be informed of what those forms are.
General Tips

Keep in mind that it will take some time to get used to living in a new place. Be kind to yourself and those around you.

If you have concerns or questions, make sure to ask the staff. If you feel that the staff is not helping you or if you feel there are issues that are not being resolved, you have a right to contact the Long Term Care Ombudsman program at:

1-800-499-0229

Some Advice from seniorresource.com

When difficult situations arise families may need to turn to social workers, case workers, hospital discharge planners, and yes, the internet to help them become educated about the options appropriate for their loved one. They may also need guidance to identify specific choices in their area. Unfortunately, choices for selecting a nursing home are often made in haste and under stressful situations.

Don’t just accept the recommendation of a professional. They may mean well and understand the level of care needed, but do not know your family, or your family member. They will know which homes will take Medicare, Medicaid, and which ones only take private pay patients. But you must be comfortable with the care that will be, or is being provided for your loved one.

Plan to do some of your own Nursing Home shopping. Ask around. Plan to visit and see how different homes “feel”, “smell” and look for those which have happier residents. Follow the guidelines outlined in the next few pages and review the Nursing Home Checklist on page 10.

Try to start shopping as soon as it seems you may need to place a loved one in a nursing home. That way you will be less stressed when you have to make the decision. If you make it in haste, it is possible to have to remake the decision later and relocate a loved one. If the first placement is hard, the second one is harder!

There is no substitute for visiting the home in person!

Federal regulations require any long-term care home or facility to provide 30 days written notice and an appropriate discharge plan if they determine a patient is inappropriate to remain with them. They may not just tell you verbally “you have to relocate a loved one!”

Moving Day

• The hospital will help arrange for transportation to your new home.

• Double check to make sure that you have instructions from the doctor to give the staff at the nursing home. This needs to include an accurate list of medicine that you are to be taking.

• Have a friend, family or caregiver come with you.

• Make sure to take all your supplies or personal items with you from the hospital. Many hospitals provide a bag for your belongings.

• After you get to the nursing home, a social worker or other staff member will greet you.
## Nursing Home Check List for: 

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it well maintained inside and out?</td>
<td>✓</td>
</tr>
<tr>
<td>Is the decor pleasing and warm?</td>
<td>✓</td>
</tr>
<tr>
<td>Is the facility free from odors?</td>
<td>✓</td>
</tr>
<tr>
<td>If there are odors, are they handled quickly?</td>
<td>✓</td>
</tr>
<tr>
<td>Do all rooms have private bathrooms?</td>
<td>✓</td>
</tr>
<tr>
<td>Are there electric beds?</td>
<td>✓</td>
</tr>
<tr>
<td>Is the attitude of the nursing staff caring and friendly?</td>
<td>✓</td>
</tr>
<tr>
<td>Are meals nutritious and appealing?</td>
<td>✓</td>
</tr>
<tr>
<td>Is the kitchen clean and orderly?</td>
<td>✓</td>
</tr>
<tr>
<td>Does a registered dietician, or professional service plan meals?</td>
<td>✓</td>
</tr>
<tr>
<td>Are there individual and group activities and a monthly calendar?</td>
<td>✓</td>
</tr>
<tr>
<td>Are arts and crafts offered?</td>
<td>✓</td>
</tr>
<tr>
<td>Are there special outings?</td>
<td>✓</td>
</tr>
<tr>
<td>Are non Medicare patients allowed to visit home?</td>
<td>✓</td>
</tr>
<tr>
<td>Do they have an active volunteer visiting program?</td>
<td>✓</td>
</tr>
<tr>
<td>Do they provide in-house physical therapy?</td>
<td>✓</td>
</tr>
<tr>
<td>Is speech and occupational therapy available?</td>
<td>✓</td>
</tr>
<tr>
<td>Are therapists licensed?</td>
<td>✓</td>
</tr>
<tr>
<td>Are religious services, or transportation to churches offered?</td>
<td>✓</td>
</tr>
<tr>
<td>If privately owned, is the owner available?</td>
<td>✓</td>
</tr>
<tr>
<td>If managed by an outside service, how do their other facilities compare?</td>
<td>✓</td>
</tr>
<tr>
<td>What is the reputation in the surrounding community?</td>
<td>✓</td>
</tr>
<tr>
<td>How does the facility treat residents with similar needs?</td>
<td>✓</td>
</tr>
</tbody>
</table>

Name of Facility

Date of Visit
Section III - Moving from a Hospital to Skilled Rehabilitation Unit

Many times you are admitted to a hospital for a period of time, and the doctor or primary care practitioner recommends rehabilitation. Rehabilitation means time to develop your strength or learn new skills that may be needed due to your recent hospitalization, like using a walker. Medicare does cover the skilled care that you need when you are in a rehabilitation facility, but there are requirements in order to use this benefit. For specific information, including how many days you need to have been hospitalized and details about what is covered for services, refer to the Medicare brochure [Medicare Coverage of Skilled Nursing Facility Care] available at their website: www.medicare.gov/publications/pubs/pdf/10153.pdf

If you do not have the internet, you can order the pamphlet from Medicare by calling: 1-800-Medicare

If you do not have Medicare as your primary medical insurance, you should contact your insurance company before you enter the rehabilitation facility so that you know exactly what will be covered for services while you are in the rehabilitation facility.

Section IV - Moving from a Hospital to Residential Care or Assisted Living

There are many types of assisted living or residential care facilities. Most types have different levels of care that they offer. Below is a list of the different types of facilities and definitions from the [Office of Elder Services website at www.maine.gov/dhhs/beas]

- **Assisted Living Program**: Are “apartment style” living arrangements where a variety of services are provided, including help with medications and, in some cases, nursing services.

- **Level I Residential Care Facility**: A one or two bed facility where residents receive room and board and services as needed.

- **Level II Residential Care Facility**: A three to six bed facility where residents receive room and board and services as needed. A family unit primarily operates these facilities.

- **Level III Residential Care Facility**: Also a three to six bed facility where residents receive room and board and services as needed. These facilities are primarily agency owned and operated and employ three or more un-related people.

- **Level IV Residential Care Facility**: A facility with more than 7 beds. They also proved room and board and services as needed.

- **Private Non-Medical Institutions (PNMI)**: A type of facility that accepts MaineCare clients. There are four levels of PNMIs; Level I, Level II, Level III, and Level IV. The definition of the Levels are the same for bed compliment as Level I - IV Residential Care Facilities.

When choosing a residential care or assisted living facility, there may be eligibility or admission requirements. Check with the facility that you are considering in order to find out if you meet the criteria for admission.

In addition, think about the following issues as you consider a move to an assisted living or residential care facility. (taken from Consumer’s Guide to Assisted Living Facilities Checklist for Consumers and Prospective Residents, prepared by The American Health Care Association National Center for Assisted Living)
Planning Ahead: A Consumer's Guide to Assisted Living Facilities Checklist for Consumers and Prospective Residents

When you are looking for an assisted living or residential care setting for yourself or a loved one, please consider the following checklist to help you make the best choice.

**Moving In**

✓ What does the moving in process entail? What are the paperwork requirements and the timeframes involved?
✓ How is the initial assessment managed? Who completes the assessment?
✓ Is the residence affiliated with a hospital or nursing home should acute or long-term care be needed? If so, is there a priority admission process?
✓ If you need hospital or nursing home care, is your room held? What are the associated fees? Is there a discount for unused services (e.g. meals)?
✓ Does the residence subscribe to a set of resident rights and responsibilities? Are they available?

**Service Planning**

✓ Are the family and the resident involved in the service planning process? How often are resident’s needs assessed? Who completes the assessment?
✓ Are there special programs for memory impaired residents and residents suffering with dementia? Are there accommodations for memory-impaired residents to be outside and exercise?
✓ Are there special programs for residents with disabilities?
✓ How are emergency situations managed? What is the protocol for such events?
✓ What happens if the health care needs of a resident change? Under what conditions are residents asked to move if there is a change in health status?

**Services and Activities**

✓ Does staff assist residents in administration of medication? If so, what kind of staff?
✓ Must the resident use the residence's pharmacy? Does the pharmacy provide a yearly review and consultation services?
✓ Are there professional nursing services on site? If not, does the staff assist residents and families in making arrangements through a home health agency?
✓ Are the services of a physical, occupational or speech therapist available or arranged?
✓ Does the residence provide bed linens and towels?
✓ Does the residence provide laundry service?
✓ Are there beauty shop services available on site?
✓ What recreational and spiritual activities are available? Obtain or review a copy of the activities calendar.
✓ Are the activity supplies available for resident use outside of scheduled programs?
✓ Is transportation provided for medical appointments and recreational purposes?
✓ Is there a resident council? How often does it meet?
✓ What are the suggestion, complaint, or grievance procedures?
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Staff
✓ Ask about the residence’s staffing patterns and philosophy about staffing.
✓ What training and qualifications are required for staff? Are there ongoing training programs provided for staff?
✓ Observe staff and resident interactions. Are they positive? Courteous?
✓ Do staff handle resident requests in a timely way?
✓ Does the residence have a volunteer program? If yes, what types of activities do the volunteers perform?
✓ Does the administrator/director practice an "open door" policy?

Costs and Fees
✓ What is included in the basic monthly cost? Ask for a written copy.
✓ Does the residence have a written schedule of fees for extra services? If so, request a copy.
✓ Under what circumstances might the fees change? How much notice is given if there is a fee increase?
✓ Is there a security deposit? What is the refund policy?
✓ Can service agreements and/or contracts be amended or modified?

Dining and Food Services
✓ Does the residence accommodate special diets?
✓ Does a dietician or nutritionist review the menus? Request or review copies of the menus.
✓ How often do the menus rotate? Are residents and families involved in menu planning?
✓ Are residents allowed to have guests for meals? Is there a separate guest dining room?
✓ What are the criteria for residents to eat meals in their rooms?

Living Space and Accommodations
✓ Are there adequate community areas for resident use?
✓ Are the resident rooms furnished or unfurnished? What is the policy about personal belongings?
✓ What is the policy for overnight guests? Are there guestrooms available? What are the guest fees?
✓ Is additional storage space available? Is there an extra fee?
✓ Does the residence meet the rules for people with disabilities?
✓ Can residents have automobiles? Is there assigned parking? Is there an extra fee?
✓ Are there patios and courtyards available for resident use? Is there an area for resident gardening?
✓ Does the residence provide security?
✓ Are pets allowed to reside in the residence? If so, are there additional fees and or deposits? If not, are pets allowed to visit?

Licensure and Certification
✓ Is the residence licensed? Ask to review the last licensing/certification report.
✓ If the state requires the administrator to be licensed or certified, is it current?
Moving From Place to Place

When moving from the hospital to your residential care or assisted living home, there are some special tips that you may find helpful in making that transition smoother. These include:

- Make sure that you have written discharge instructions, including a current medication list signed and dated by your discharging physician or primary care practitioner. This will help to ensure that you have exactly what you need before you get home.

- On the day of discharge, make sure that you understand any new treatments, medications, or therapies that you need when you return home. This will help you guide your residential care or assisted living staff in helping you when you get home. Asking for pictures or clear directions is always helpful.

- Make sure that you have all your clothing, hearing aids, dentures, and any other personal items that you brought with you to the hospital. It is often easier to find items while you are in the facility. Have the person assisting you arrange for transportation to your residential care or assisted living home.

Final Checklist Prior to Signing the Service Contract

This checklist is provided to the family and prospective resident as a final tool once an assisted living residence has been chosen. Use this as a reminder for issues which need to be addressed and fully understood.

Make sure you:
- Know what the basic service package includes
- Know all costs associated with your service package
- Know about additional services and their associated fees (e.g., medication management)
- Know the circumstances why fees might change and how much notice is given to families and residents
- Understand the services planning process
- Understand the service contract
- Know about the criteria and policies associated with discharge
- Understand resident rights and responsibilities
- Know the residence’s grievance policy and procedure
- Understand how many staff are available and their qualifications
- Have the name and telephone number of the staff contact person

When moving from the hospital to your residential care or assisted living home, there are some special tips that you may find helpful in making that transition smoother. These include:

- Make sure that you have written discharge instructions, including a current medication list signed and dated by your discharging physician or primary care practitioner. This will help to ensure that you have exactly what you need before you get home.

- On the day of discharge, make sure that you understand any new treatments, medications, or therapies that you need when you return home. This will help you guide your residential care or assisted living staff in helping you when you get home. Asking for pictures or clear directions is always helpful.

- Make sure that you have all your clothing, hearing aids, dentures, and any other personal items that you brought with you to the hospital. It is often easier to find items while you are in the facility. Have the person assisting you arrange for transportation to your residential care or assisted living home.
**Section V - Moving from a Nursing Home to Your Home**

Moving from a nursing home back home is often a challenging transition. Although it is exciting to be returning home, it is important that you identify your needs and have plans in place to address them. Some of the most important considerations are as follows:

Talk with your social worker or discharge planner about what your home is like. Many times, a nursing facility will send out an occupational therapist or a physical therapist to make sure that your home is safe for you before you get home. This is also a time to discuss what services you may need at home and develop a plan to get the services that you need. This may include a Goold assessment or a Medicare home health evaluation.

Check with family, friends and church members about what they may be able to help you with when you return home. Make sure to get specific days, times, and what they will be able to help with. Often family/friends have the best intentions of helping you at home, but may not be able to provide all the support that you need. Developing a written plan will definitely assist you in knowing who will do what.

If you require services in the home, like transportation, meals for me, or assistance in applying for food stamps, or heating assistance for example, contact your local area agency on aging and they can help you get to the most locally appropriate resource in your area. This may include a referral to a Community Action program, a private pay housekeeper, or other community based programs.

**Section VI - Teamwork Starts with You: Keeping Tabs on Your Medications and Medical Conditions**

Health care transitions usually involve changes in your medical providers. Because communications can break down, special efforts must be made to assure that mistakes and misunderstandings about your care do not happen. You and your main caregiver can contribute to successful teamwork in your care by keeping your own record of medical conditions and medications you are taking and sharing it with each new provider in your care.

For these reasons we strongly urge you to use the Personal Health Record in the following two pages (either copy or tear out). Included is a Patient Transitions Checklist, which can be very helpful to assure that plans are properly set to assure a smooth transition to your next phase of care. Because of the critical importance and potential risks of medications in your care, ask yourself the following questions prior to leaving your current care setting:

- Do you have a READABLE list of your new medications on your discharge forms?
- Do you know how much of the new medication(s) to take and what time to take them?
- Do you know the side effects of the new medication(s)?
- Do you know whether the doctor wants you to continue with medications you were taking before you entered the facility?
- Can you afford your new medications?
- Do you know if they called your prescriptions to the pharmacy of your choice?

If you answered No to any of the above questions, ask your nurse or your social worker to get you the answers BEFORE YOU LEAVE to go to your new location.
Moving From Place to Place

Personal Health Record

If you have questions or concerns, Contact (__________) at (____) ____-

REMEMBER to take this Record with you to all your doctor visits

The Personal Health Record of:

Personal Information
Address:

Home Phone#: Alternate Phone #: Birth Date: Hospital ID #: PCP Name: Advance Directives?:

Hospitalization Information
Admitted: __/__/__ Discharged: __/__/__ Reason for Hospitalization:

Caregiver Information
Name: Home Phone #: Alternate Phone #: Relation to Patient:

Medical History

☐ Arthritis
☐ Abnormal Heart Rhythm
☐ Cancer
☐ Diabetes
☐ Hardening of the Arteries
☐ Heart Disease
☐ Heart Failure
☐ High Blood Pressure
☐ Hip Fracture
☐ Lung Disease
☐ Medical/Surgical Back conditions
☐ Pneumonia
☐ Stroke
Other Diagnoses:

To better manage my health and medications, I will...

- Take this Personal Health Record with me wherever I go, including ALL doctor visits and future hospitalizations.
- Call my doctor if I have questions about my medications or if I want to change how I take my medications.
- Tell my doctors about ALL medications I am taking, including over-the-counter drugs, vitamins, and herbal formulas.
- Update my Medication Record with any changes to my medications.
- Know why I am taking each of my medications.
- Know how much, when, and for how long I am to take each medication.
- Know possible medication side effects to watch out for and what to do if I notice any.
## Patient Transitions Checklist

- I have been involved in decisions about what will take place after I leave the facility.
- I understand where I am going after I leave this facility and what will happen to me once I arrive.
- I have the name and phone number of a person I should contact if a problem should arise during my transfer.
- I understand what my medications are, how to obtain them and how to take them.
- I understand the potential side effects of my medications and whom I should call if I experience them.
- I understand what symptoms I need to watch out for and whom to call should I notice them.
- I understand how to keep my health problems from getting worse.
- My doctor or nurse has answered my most important questions prior to leaving the facility.
- My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- If I am going directly home, I have scheduled a follow-up appointment with my doctor and I have transportation to this appointment.

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This tool was developed by Dr. Eric Coleman, University of Colorado Health Sciences Center - www.caretransition.org

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Section VII - Special Considerations

Alzheimer Disease and Other Related Dementias

Many times a senior has special needs that impact moves. One of those special needs is Alzheimer's disease or other related dementia. The Maine Alzheimers Association (www.mainealz.org) is a statewide program which provides the first stop for information and assistance to people with Alzheimer's disease and their caregivers. The Maine Alzheimers Association provides resources for information about the disease, emotional support, and assistance with community resources. The Maine Alzheimer's Association also maintains a listing of residential care and community living facilities that help serve people with Alzheimer's Disease. The Maine Alzheimers Association has a 24 hour help line available toll free at:

1-800-660-2871

Making the Transition on Behalf of the Person with Dementia

Remember that you know the person with dementia better than anyone else. The transition can be difficult for everyone involved. It's helpful to approach the transition in a way that will create a positive experience for the person. Each person with dementia is different, therefore there is no single approach to transitioning that fits for all people. Assessment and planning by professionals and family at every stage of the transition is critical.

Share information about the upcoming move based on the person's ability to understand what's happening, as well as, his or her ability to handle stress. There may be resentment, resistance and the person may blame you for having to move. Please do not let this reaction change your mind about the move.

Highlight all of the positive things about the move and assess the person's response. If the person with dementia gets upset when the move is brought up you may have to quietly proceed without the person's involvement. Dementia affects the person's ability to reason, so do not attempt to convince the person that this move is in his or her best interest.

Acquaint yourself with the staff at the care setting and allow them to make suggestions about the transition. Allow them to get to know the person with dementia better by:

- Providing photographs from the person's life.
- Sharing stories or memories about the person prior to his or her diagnosis.
- Preparing a written personal history.
- Explaining favorite hobbies, activities and interests.
- Relaying caregiver tips that worked for you.

If able, prior to the move, have the person with dementia pick out personal belongings that he or she wants to take to the new home. Decorate the room with the person's personal belongings prior to bringing the person into the room for the first time.

Try not to show your own fear and sadness about the move to the person with dementia. Get information about available dementia support services in your community from the Maine Alzheimer's Association 1-800-660-2871 or www.mainealz.org

After the Move

Once the person has moved, try to visit often during the first few weeks to help the person feel secure.
Allow time for your loved one to adjust to the new surroundings. If the person insists returning home with you, this may be his or her way to express anxiety or unhappiness. Give the person reassurance and affection.

Questions to Ask
• What measures are in place to provide a safe and secure environment for person's with dementia? Examples include secure doors, safety features in the bathrooms and hallways, lighting, etc.
• Are there safe areas that allow for independent wandering? Are there outdoor areas for residents that are safe and secure?
• How does staff work with behaviors? What is your policy regarding physical restraints [devices that prevent movement]?
• Do all residents eat and sleep at the same time or is each resident allowed to maintain a similar schedule as they did at home?
• Are residents able to engage in meaningful activities that reflect their life long interest? Examples would be ironing, playing piano, helping others less able, gardening, etc.

Things to Look for
• Clean and well-groomed residents
• Residents smiling and looking happy and comfortable
• Staff talking kindly to residents, not talking over them
• Appetizing food
• Staff gently encouraging residents to do things for themselves (e.g. walking, eating, etc.)
• A copy of the weekly or monthly menu
• A pleasing atmosphere in the dining area
• Personal belongings decorating resident rooms
• Residents moving about freely in a safe area
• Pleasant smells (no or unexplainable odors)
• Clutter free hallways
• Appropriate noise level that won’t cause increased agitation (e.g. overhead speakers, buzzers, televisions on regardless of anyone watching it, etc.)

Other Special Needs
For adults seeking long term care support services in the community, including adults with disabilities, cognitive, mental health or mental retardation, or seniors, living in Penobsot, Piscataquis, Hancock and Washington counties, the DASH network, housed at the Eastern Agency on Aging is available to help you with finding the services that you need in the community. The DASH network is a collaborative project of the Department of Health and Human Services funded by the Administration on Aging and the Centers for Medicare and Medicaid. The United Way of Eastern Maine is a key collaborative partner who helps coordinate the DASH network.

To get help, contact the DASH network at:
1-800-432-7812
or in the local Bangor calling area
207-941-2865
Moving From Place to Place

Section VIII - Resources by Phone and Internet

State of Maine Office of Elder Services
1-800-262-2232, 8am to 5pm
TTY 1-800-606-0215
www.maine.gov/dhhs/beas/
Provides information and support to all seniors in Maine. Manages all state and federal long term care programs in Maine including services provided by Goold Health Systems and Elder Independence of Maine. Especially useful on Services page of Website are “Resource Directory” and “Home Care: Where to Find It”

211 Maine - DIAL 211
www.211maine.com
Offers program and contact information for health and social services from agencies throughout the state. Online search function sorts retrieved results by closeness to specified zip code.

Area Agencies on Aging
1-877-ELDERS1 (353-3771)
Connects to appropriate Agency on Aging, including Aroostook Area Agency on Aging (Aroostook County) and Eastern Agency on Aging (Penobscot, Piscataquis, Hancock, and Washington Counties). Programs include Meals for Me, family caregiver support, health insurance counseling, and help on Medicare prescription drug benefits.

Disabilities and Aging Services Helpline (DASH Network)
1-207-941-2865 or 1-800-432-7812
www.eaaa.org
Program of Eastern Agency on Aging and Maine which provides information and assistance on long term care issues.

Community Action Programs
Major resource for transportation, housing, and heating assistance programs, as well as Keeping Seniors at Home, a home modification program.
- Penquis CAP-Serving Penobscot and Piscataquis Counties
  1-866-853-5969
- Washington Hancock CAP - Serving Washington and Hancock Counties
  1-800-828-7544
- Aroostook CAP-Aroostook County
  1-800-432-7881

Long-Term Care Ombudsman
1-800-492-0229
www.maineombudsman.org
Provides advocacy and advice to help resolve problems with long term care services or in accessing services.

Medicare -1-800-MEDICARE
www.medicare.gov
The Centers for Medicare and Medicaid have many general publications and helpful resources related to long term care planning. Especially useful is their “Guide to Choosing a Nursing Home” (www.medicare.gov/Publications/Pubs/pdf/nhguide.pdf). See also resources at the National Clearinghouse for Long-Term Care Information (www.longtermcare.gov).
Section IX - What do all these Different Words Mean?

A Glossary of Terms

**Advanced Directives/Living Wills** - Legal papers that let your healthcare professionals know what you want them to do if you become unable to make your own decisions about your medical care.

**Activities of Daily Living or ADL's** - What you do on a daily basis to take care of yourself. They include taking a bath or shower, walking or using wheelchairs, dressing, moving around from one spot to another, eating, and personal hygiene.

**Case Mix** - A term used by nursing facilities and agencies to describe the level of need of the patients that they serve. For example, a facility may have a high case mix of people who need total help with their personal care such as in a nursing home.

**CNA or Certified Nurses Aide** - A person who is certified to assist people with personal care and transfers. They are required to be listed on a registry and operate under Maine rules and are accountable to the Board of Nursing.

**Cognitive ability** - A person's ability to remember things, or ability to think and process ideas.

**Dementia** - A type of memory loss that can be a result of medical problems or medication side effects. Dementia requires a complete medical exam to determine the root cause and to rule out Alzheimer's disease.

"A Goold", "Goold Assessment", "An Assessment" or "GHS referral" - All refer to abbreviations for the Goold Assessment process often used by professional staff.

**HHRG** - This is an abbreviation for Home Health Resource Group which is a Medicare name related to billing for home health services and is what home health agencies use to determine correct amounts to bill.

**Homemaker** - A person who provides help with grocery shopping, laundry, housekeeping and sometimes, assists with errands.

**Hospitalist** - A physician who spends at least 25 percent of their professional time serving as primary doctor for a person while they are in a hospital. Upon discharge from a hospital, the person returns to the care of their primary care provider.

**IADLs or Independent Activities of Daily Living** - Services that are needed to help you support yourself on a daily basis which includes grocery shopping, doing laundry, and cleaning your home or apartment.

**Long Term Care Ombudsman Program** - This is a service offered in Maine to any consumer or family that is using any form of long term care, including nursing home, home health or assisted living. The volunteers and social workers on the staff can help you with issues that you have with the agency or provider and they work to help you with solutions.

**Long term care services** - Any services that provide help to a senior or person with disability live on a daily basis. These include home health services, residential care, community based services, and volunteer or other types of support services.
Moving From Place to Place

A Glossary of Terms (continued)

Medicare certified agency - An agency or hospital that has met the requirements that Medicare determines in order to serve Medicare patients. Meds- An abbreviation for medications, drugs, or medicine.

MME - An abbreviation for the Mini Mental Status Exam that is often performed when a consumer is being looked at for dementia or Alzheimer's disease.

PSS or PCA - These are abbreviations for the same level of staff, a Personal Support Specialist, who is often working in a person's home. They are not currently listed on a registry; however, many agencies who hire PSS staff do conduct criminal background checks on this level of staff and provide professional training for these staff.

Nurse or R.N. - Refers to a Registered Professional Nurse. These are nurses that are required to be licensed in the state of Maine. They practice under state of Maine rules and are accountable to the Maine State Board of Nursing.

Residential care - A term used to describe facilities which provide support services to people who live there. Also have been referred to as boarding homes, assisted living, or "Res. Care" by professionals.

NF - A nursing facility or nursing home.

SNF or SNIFF - Skilled Nursing Facilities; a nursing facility that also provides rehabilitation services.

Prepared by Valerie Sauda, Director of Community Services, Eastern Agency on Aging under guidance from the Transitions with Care Advisory Committee. Special thanks for contributions by Michael Edwards and Carol Carew (HealthWays/Regional Medical Center at Lubec), Peg Gagnon (Alzheimer's Association, Maine Chapter), Sharon Ann Berz (Aroostook Area Agency on Aging), Tim King (Washington Hancock Community Agency), Jennifer Crittenden (University of Maine Center on Aging), and Julie Ireland (Eastern Maine Medical Center). Suggested improvements and corrections to this manual are welcome (contact: vsauda@eaaa.org).