

Kathryn Sexson, PhD, APRN, FNP-BC: Today, we're going to talk about how to advance your skills in supporting the family caregiver. By the end of our hour together, you should be able to describe the varied roles of the unpaid caregiver, identify the challenges of the caregiving experience, establish strategies to support the caregiver, discuss resources and a plan of care for self-care, as well as recognize the importance of maintaining caregiver wellbeing by understanding the motivation and the intrinsic value of the role. So let's start with what are the common roles that family caregivers fulfill. They're quite varied and they cover a range of professional responsibilities. We ask them to provide a level of care often equivalent to that of the professional nurse. We expect them to be able to monitor acute and chronic conditions recognizing early signs of impending problems and knowing when to respond and how to respond. We ask them to perform complex care tasks, often managing complex medication regimens, feeding pumps, IV pumps, antibiotic pumps, peripheral IV lines, PICC lines, central venous catheters, being able to provide wound care, including managing drains and negative pressure wound VACs, being able to perform catheterizations and tracheostomy care. Things that as nurses, we went to school for years to learn. We expect them to learn and what translates to really a matter of minutes. There was a recent study conducted through AARP that looked at the amount of time that we actually notify caregivers about a discharge. When that teaching really gets started for many individuals and what they discovered was that 65% of people had less than 24 hours notice of discharge, 15% were not notified at all. So the care recipient actually arrived at home prior to the caregiver knowing that they were going home.

So when you think about that, 80% of people really have minimal time with teaching. They're often unprepared, lacking either knowledge or skill, and when failure happens, they often experience guilt and shame, especially if there's an adverse outcome. We ask them to assume the role of the psychologist or the social worker and provide emotional support even though their relationship may have left connection, been dysfunctional or even abusive prior to engaging in their caregiving activities. We ask them to be the care coordinator arranging for in-home and

community support services. We ask them to be the care navigators, accessing help and information from the healthcare system, which is not always easy task we would like it to be. Many caregivers who are healthcare providers often share with me that they had no idea how challenging the system was to actually navigate for someone who knows it, let alone someone who doesn't. We ask the family caregiver to assume the role of the emergency services provider and to respond to emergencies as they arise. We ask them to become the financial advisor and the performers of chore services, the contractor, the handyman, the person who pays bills and manages finances, managing laundry, preparing meals, performing shopping, running errands, maintaining the home. We ask them to become the certified nursing assistant, performing intimate, personal care, bathing, dressing, feeding, oral care, hair care, skin and nail care, toileting, managing incontinence as well as continence. And that can be challenging, not only from the skill perspective, but emotionally as this may be the first time they've seen their parent naked, the first time they're going to be doing perineal care on somebody that they care about and was never actually intended to be their role when they signed up as child or spouse or friend. And that can be psychologically complex, not just for the caregiver, but also the care recipient, which can trigger a whole realm of different emotional responses. Finally, we ask them to be the physical therapist, the occupational therapist and the speech therapist using correct body mechanics, correct techniques and assistive devices. And we expect competence in all of these areas.

. They oftentimes also become the defacto decision-maker and the importance of shared decision-making with the care recipient, the caregiver and the healthcare team cannot be stressed enough. They're often looking at making decisions around financial and legal matters, advancing care planning, and setting up the pulse, the DNR or the full code. They're making treatment decisions. And probably one of the biggest challenges is for them to become the family mediator, often resolving family disagreements about the best ways to provide care or where care should be provided. So if you haven't started tallying up the challenges that we're going to talk about in more detail. As you can imagine, when they're unprepared to assume any of the myriad

of roles their strain increases. What does that actually look like for them? What we know from the research that's been done is that they're likely to have increased blood pressure, increased risk of heart attack and stroke, increase in depressive symptoms and anxiety systems, all of which are poor health outcomes for the caregiver. Dementia caregivers often see increased strain beyond other caregivers. Nothing is predictable when you're taking care of someone with dementia. They may get their sleep-wake cycle turned around. And when that sleep disruption occurs for the care recipient, it occurs for the caregiver. That puts the caregiver at risk for obesity, cardiovascular disease, increased cancer risk, cognitive impairment themselves and a myriad of other challenges. The financial implications for many are extreme and not something we often think about. Many reduce their work hours with 50% of caregivers reducing the time they spend at work to fulfill their caregiving responsibilities. Not only does that impact their day-to-day income, but they may lose medical benefits if they drop below their organization's minimums, that will decrease their retirement earnings. Societally, that impact decreases tax contributions to fund existing and future social security and Medicare recipients. So it's a far reaching impact when folks need to step away from their work lives to provide care. There is very little setup for [inaudible] for family caregivers.

FMLA, which is the family medical leave act guarantees a return to similar position for 12 weeks, but that's unpaid time away. There are some states that have programs where the family member can assume a paid caregiver role, but that [inaudible] often translates to \$5 to \$6 an hour, which you can imagine can be very difficult to live on. There may be guilt when errors occur or when they have to break promises that they've made to the care recipient. When folks have been caregiving for a long time and it's become more and more challenging, sometimes there's that wish for an end. Sometimes there's guilt over actions that they've taken when their resilience is exhausted and all of that can contribute to feelings of guilt and shame. Family dynamics, that those of us who've worked with families who are in the caregiving role. Oftentimes we find that caregivers and care recipients may have had those dysfunctional relationships prior and are assuming those roles now that does not change those pre-existing behaviors. Other members of

the caregiving group, who don't always agree on the best courses of action. There may be discussions there about what to do and that can sometimes create divides in families. Or my personal favorite is what I call the backseat driver or the Monday morning quarterback who would like to share their insights on caregiving, but they have no actual time to participate in the role. That oftentimes can lead to those feelings of resentment for the person who's in the role 24/7, 365 when others would like to tell them how to do it better, but without offering any support. So that can create an additional emotional challenge for those people. And then challenging to maintain and manage their own wellbeing. A suggestion that sounds relatively simple is go to the gym a few days a week. I can remember being the caregiver for my father who suffered from a hypoxic event and developed dementia. When I looked at going to the gym, to hire someone to come in to be with him was a four-hour minimum, \$30 an hour, three days a week translated to \$360 a week, which then was \$1,440 a month plus the gym fees. And there was no way that I could come up with \$1,500 a month so I could go to the gym. So sometimes the suggestions we think are easy when we don't understand the full ramifications and don't have that relationship or time to spend with the caregiver. We may not realize that our great suggestion isn't implementable in their environment.

So how do we support them? As I alluded to earlier, assessing preparedness is critical. The caregiver preparedness scale and I've provided the link here is a valid and reliable tool to assess preparedness. There is also a document called the family caregiver domains of preparedness that's available on the Family Caregiving Institute's website that goes into even more detail so that you can sort of tease out the nuances for each person that you're assessing. Education with teach back is important rather than just simply giving folks a piece of paper for reference, because nobody really knows the questions they have until they actually try to do something. This helps us target the interventions that we utilize to enhance their preparedness. If it's available, incorporating a care navigator or care coordinator does not only help with the navigation of our healthcare system, but also access resources that the care recipient and the caregiver may be eligible for, that they aren't aware of. And that can be an invaluable resource

for them. The other areas that is huge for this group is policy and advocacy. Across the nation, transitions in care present the most challenge for these individuals, whether that's home to hospital, hospital to home, to and from assisted livings or to and from skilled nursing facilities. There are policies at the organization, local, state, regional and national levels that could be implemented to enhance the outcomes during these critical junctures, because these are the places where most commonly things go awry. Financial support and job protections beyond the three months that include extended family, as well as immediate family and expand the availability beyond companies who have 50 employees, because a lot of those protections at the national level are only attributable to larger organizations. And there are many others- excuse me, I'm going to get a quick drink of water here. So there are many other opportunities. And as you become more aware of what's available within your locations, you may identify opportunities and there are organizations that you can partner with such as the association on aging or AARP that are doing a lot of policy work to help enhance what's available to family caregivers. Probably, the hardest piece for most caregivers is that caregiver wellbeing component.

Being prepared enhances wellbeing. Being financially stable may enhance wellbeing. The self-care definitely contributes, but it can be difficult to figure out ways to actually take care of yourself so that you can continue to take care of other people, because oftentimes for caregivers, it's not just the care recipient, but they have families that they're providing care to. They're trying to work. There's a myriad of responsibilities. And if they aren't able to take care of themselves, doing that becomes almost an impossible task. Oftentimes, when I talk to caregivers, I hear one of these responses. I don't remember the last time I did something to take care of myself. I've forgotten what that is. I don't have time. My family needs me or that value of self-care is just being selfish. Others need to come first. I'm sure that in your interactions with caregivers, you've heard variations of this over time. So how do you actually respond to that? Because it's such an important skill for family caregivers to actually learn how to do. So when people share that they've forgotten, what self-care is, I encourage them to make a list of activities and ideas of things that they like to do. Things that actually sort of nourish their being and include break of

time, because sometimes you think, oh, I need an hour to do that, or I need 30 minutes to do that. But sometimes you can find things that take just a few minutes. So having a break when you need to take a break is really important. Also, make sure that connection is part of that list, because caregivers tend to self-isolate. As their responsibilities grow, their world shrinks. And then it becomes completely about the caregiving responsibilities, which we know contributes to poor health outcomes as well. So making a list of people that you can call and people you know will understand, hi, I just wanted to talk for a minute. Mom's calling. Got to go. So these are folks who are really your support network, who will never be offended if you need to hop off right away, or you just need to do a primal scream and say, thank you and hang up. Join a support group. There are now many support groups that are online. So sometimes people are reticent to connect, if the care recipient can hear them.

So those online support groups where people can do chats when the privacy of their computers so that the person they're providing care to doesn't feel like they have become a burden because the caregiver needs support. It's a common concern of many caregivers not to be perceived that way but needing an outlet to bounce ideas off each other to just share it was a hard day or even to share it was a really good day, what worked especially well that day. Attending events or taking a class. So as I said, connection to avoid isolation is really important. When you think about, I don't have time, maybe it's that you need some encouragement to think of a list of activities. So things as simple as close your eyes and breathe. Have a non-alcoholic beverage and take a moment to really taste it, feel its warmth or coolness, enjoy the flavor. Go outside. Leave your cell phone inside and use your five senses to ground yourself. What do you see? What do you hear? What do you smell? What do you feel on your skin? Or what's the emotion that you're experiencing? If you have something to taste, what does it taste like? That can take a minute tops, even 30 seconds, just for that quick re-centering. Keeping a gratitude journal where you jot down the things that you were grateful for, for the day. Sometimes it's, I woke up. Sometimes it's, I'm crawling into bed. These don't have to be big life changing revelations of gratitude. They can be very simple. Finding the humor in what's happening. Taking time to

laugh, either with family, with friends, with the care recipient, even with yourself. You went to do something and it didn't turn out the way you planned. It can actually be pretty humorous. Phoning the friend, writing a letter, giving permission that you don't have to sit down and finish the letter. It might take you several weeks to write that letter, but it can be a time to recharge. Coloring is also fabulous for a start-stop activity. And the stress relieving value of that has really started to come to light in the research. If you have time, you can exercise, simple stretching, taking a nap or a power snooze things that don't take much time, but offer rewards in spades for your wellbeing. So one of the last things that we're going to talk about and explore briefly is the motivation for caregiving and how to facilitate intrinsic motivation.

So just a few key terms before we jump in to be sure we're all on the same page. We're going to talk about these factors and how their enhancement may serve as strategies to reducing unhealthy outcomes. So the first one is autonomy, which involves the ability to make choices, understanding a range of options and planning for the future. Competence refers to feeling informed and understanding the diagnosis and the treatment for which you are going to be engaging. Relatedness is connecting with others who are in similar situations. And mutuality is when their relationship is characterized by love and affection, shared pleasurable activities, shared values and where empathy exists for each other. All of these things when enhanced can positively impact caregiver wellbeing, and when there are distractions, they can undermine positive health outcomes. So let's talk about sources of motivation for caregiving. There was a group of three researchers, Don Stein [inaudible] who published an integrative review of the literature in 2020 that examined motivation from the perspective of self-determination theory, which is really quite interesting to think about as you would expect different reasons for engaging in helping behaviors correlated with how people actually experience stress and wellbeing. So let's talk about extrinsic motivation first. That's when people feel forced or obligated to provide care. And as you might surmise, these individuals experience decreased wellbeing with increased exhaustion, perceived stress, depressive symptoms, decreased life satisfaction and increased caregiver burden. Whereas those who experienced intrinsic motivation experienced

less burden, less strain and an increased quality of life. So what does intrinsic motivation actually look like? These are folks who will share they're committed to helping and derive enjoyment from doing so. Their psychological needs for relatedness, autonomy and competence are met through caregiving, which translates to increase life satisfaction, a subjective sense of vitality, positive aspect and greater spirituality.

When people feel the care recipient appreciates, what they do, they have a greater sense of willingness to help. And as [inaudible] Stewart and Harvest discovered almost several decades ago now, high levels of mutuality also translate to less feelings of burden, strain and that increased quality of life. So how do we take this and translate it to practice. So early identification of needs, of course, results in better psychological coping and health outcomes. So assessing that preparedness early and often is important, not assuming because we assessed it once and we provided them with the strategy that that was successful. So doing those check-ins to be sure that they're still feeling prepared, that they don't need more assistance to develop their tool kit for action is important. Offering options and communicating the range of possibilities through shared decision-making is of utmost importance. And for us as providers, making sure that we understand our own values and being sure that when we're doing shared decision-making, it is not our value system that we're presenting, but we're actually hearing their value system and ensuring that the strategies and the options we are presenting encompass both. Sharing resources and strategies that will increase connection and relatedness. And finally treating them as partners and truly integrating them in the team, rather than just delegating to them. Strategies to accomplish this might include avoiding criticizing or blaming and giving encouragement instead. So avoiding that why did you do it like that, which automatically sets people up for defense, I did it wrong. You might try something like, wow, you did that part really well. What challenges did you face in this next part when you tried it? Oftentimes, for me, those are what I call my Eureka moments because I never thought about it like that. So I flat out tell the caregiver that I say I never thought about that. Let's think about how we might solve that. Tell me more about what you have at home or tell me how your house is set up. So you're

strategizing together, looking at those options to facilitate the next piece in the puzzle and increased choice and collaboration. See them as no less important than provision of care than the care recipient. So asking how are you doing, not just how is the care recipient doing.

Treating them as an integral part of the healthcare team as they're truly part of it and engage them in that decision-making, rather than giving them the litany of the education about the tasks they're going to be performing, and recognizing them as resilient and capable people, and finally helping them stay connected and connecting with people that they don't have to explain everything to, that relatedness can be so important to just immediately be able to skip over, I felt like this [inaudible], just to be able to articulate it with somebody who's walking in those shoes can be huge. Resources are especially key and resources, they can access after hours and on weekends. I've included links here to multiple resources to help you. And I chose these particular ones as they have evidence-based approaches to caregiving. So just a few highlights, the Family Caregiving Alliance and The National Alliance for Caregiving, they offer a breadth of resources, including ways to enhance connectedness as does the Alzheimer's Association. AARP has excellent policy updates for both people interested in helping move policy forward and folks who want to see what policies currently exist and what work might be available to be done. And then they also have, how to video series for complex care to be used by caregivers. And most of those now are available in multiple languages. So that can often augment the teaching when people are at home and they have one of those complex care tasks to do that they nodded and said, yes, I have it, but when they got home to do it, it wasn't as well strategized as it needed to be, because they forgot to tell us something, or we forgot to ask. The Veterans Affairs site has an awesome self-care module, well worth taking a look at. And then the Family Caregiving Institute is another resource, both for caregivers who want to engage directly with a healthcare professional to address their individual needs, as well as offering resources for healthcare professionals. So the resources for those of you, who'd like to delve more deeply into understanding ways to improve health outcomes for both the caregivers and the care recipients, there are three online interactive educational course offerings with both asynchronous and

synchronous activities, all conducted either over Zoom or in that asynchronous environment that are housed under the graduate academic certificate. And they translate theory behind what enhances or undermines caregiving success into practice, exploring valid and reliable instruments for doing those preparedness assessments, the strain, the burden, the wellbeing assessments.

The second course addresses health literacy and family centered communication, looks at ethical dilemmas that are commonly faced and shared decision-making across cultures, including how to evaluate your shared decision-making to be sure you're doing as good of a job as we think we are, or we're doing a great job, but there's still room to make that even better. And then the last course synthesizes all of that knowledge for students and healthcare professionals engaged in integration of the family caregiver in the co-creation of plans of care, as well as exploring opportunities for advocacy. Modules are also under development to include asynchronous and synchronous learning opportunities. Pulling from the expertise of the Institute faculty, we have visiting faculty from across the nation, as well as faculty housed in the Institute itself, making some of the content from the certificate program available to working professions in smaller chunks as continuing education opportunities. So thank you so much for your time today. I hope that this has stimulated some excitement for each of you about our ability to really enhance the lives of this exceedingly important group of individuals who comprise almost a quarter of the adult population over 45 and now 25% of millennials. They're providing over 34 billion hours of care to an adult with limitations in daily activities, the estimated economic value of which exceeds \$470 billion. That's more than the agricultural, mining, and forestry industries combined contribute to the US economy. So this is huge and anything that we can do to augment their preparedness, augment their wellbeing will serve them well and the people that they are providing care to. So I'd like to open it up to all of you for any questions you might have.

Rebecca Gleason: Thank you, Dr. Sexson. That was a fabulous presentation. I want to remind everyone that you can ask questions in the Q and A box and it'll come through. And then Dr. Sexson will

be able to answer them. The first question that we'd like to ask would be what is the best resource to provide for caregivers, looking for placement options for their loved ones, both respite and permanent placement options?

Dr. Sexson: So if it is going from hospital back into the community and that particular transitions space, the care coordinators or discharge planners at the hospital facilities usually have a list of resources for what are the respite options available in your area. If somebody happens to be on palliative care or hospice, there are some benefits for respite five days a month that are available through those options. Each state or community may have various options. There is very little free respite. So knowing what financial resources or benefits might be available will be integral for that component. As far as placement options, every state does have a department of senior services and most of them have placement options or licensed facilities on their websites. Most of them include the ratings for those institutions. If they're skilled nursing, the Medicare ratings on those institutions, or if there has been an ombudsman calls in, if there's a complaint filed that is noted on those websites to help people look at quality. The Alzheimer's Association, if there is a dementia component involved and it doesn't have to be just Alzheimer's, any type of cognitive impairment. Many of them have care coordinators who can help navigate what are the respite services available in your area and how to access those. As far as making decisions about placement, the Family Caregiving Alliance has a really nice section on their website that sort of walks through what are the questions I should be asking. Make sure that you share a meal when you go, because I will tell you food is probably the sole source of the most complaints that you hear in any type of assisted living placement. So knowing whether or not the food is compatible with your care recipient will save people hours of frustration, because people will focus on what they can control. So if it's the care recipient is unhappy with the food, that will become a major source of discussion. And so those are probably the best ideas. If you had individual questions that we could troubleshoot through, I'm happy to communicate with you directly to work through some of that, if it's helpful.

R. Gleason: Thank you. The next question is, can you speak to depression and the sense of loss that a caregiver might experience once a patient or family member has passed?

Dr. Sexson: Absolutely, especially for those individuals who have become this sole caregiver for someone where their identity has been sort of wrapped up in that caregiving role. And when that person is no longer with us, reclaiming self can sometimes be a very arduous process knowing what to do with your time. And so if hospice has been involved, they too have bereavement services after people pass and that can be extremely helpful for caregivers to have that process and that support available to them as they work through life after caregiving. There's also anticipatory grief with the dementia caregivers. So that sense of losing someone before they're gone, which can be devastating for many people, working with caregiver support services with the silver lining of COVID with the amount of tele-health now being provided, linking with a psychologist or a licensed clinical social worker who can help people navigate through the emotions of both anticipatory loss and the loss when it finally arrives can be exceptionally helpful. Some of the support groups also have loss groups associated with them. So that can be an incredible source of support for people. And of course, family and friends who understand and realize that everybody grieves differently and that time for grieving can be very short depending on what work people have done prior to the actual death, or it can be extremely long. And for some folks, it becomes pathologic in nature if there are pieces they just can't let go of. So definitely reach out to the social workers for help with that one when the need arises. They're fabulous with doing that.

R. Gleason: That leads quite well into the next question about some strategies that may help the caregivers, who might not even realize that need care as well. So basically they want to know if there's any strategies in place for actually the caregiver themselves who are so busy caring for someone that they don't even realize that they have some needs too.

Dr. Sexson: And that can be very challenging because for many people, when they become caregivers, it's all about the other person and they don't recognize that they haven't been taking care of themselves. So if you're working with someone who is a caregiver, even asking that simple question of when's the last time that you did something just for you. Sometimes that can open the door, asking the caregiver, how they're doing. Maybe the first time they've been asked that since they became a caregiver. That can open the door. Working with their primary care provider is another way. And then there are some pilot projects starting with incorporating caregiver assessment and caregiver meetings into the healthcare visits. So when people, the care recipient is coming, the caregiver is also given time and space to address issues and concerns that have come up and then just making sure everyone's in the loop, caregiver included- gosh, I've noticed that you're looking a lot tired lately. Tell me what's going on. So they don't feel like we're kind of backdooring their health, but they're part of that discussion.

R. Gleason: With that, there was a question about if there's any data on the increase of substance use among caregivers.

Dr. Sexson: Sadly, yes. Definitely if you have someone who is caregiving, that is an area we should be assessing. Many times what starts out as an innocuous glass of wine can become that binge drinking or one glass becomes two becomes three becomes four. Just for those respite pieces, people sort of start getting into that mindset. And if there is a risk of substance use disorder, it can kind of spiral out of control before people realize it. So really making sure that we're asking the questions so that we can identify and help people who are starting down that path is of significant importance.

R. Gleason: And you somewhat answered this question, but they- somebody wanted you to emphasize more on the risks of caregivers' health problems that may develop for them themselves.

Dr. Sexson: Yeah. So depression, depressive symptoms, anxiety, and then all of the impacts of stress, especially if it's perceived as negative stress, as opposed to positive motivational stress. So that negative perception of stress we know activates cortisol. It's that fight or flight response that doesn't get released. And so cortisol becomes our main hormone that is released. And with that, we see increases in blood sugars. So more chance of diabetes. We see suppression of immune systems. So we see increased risk of infections. We see increased risk of cancer developing, especially as caregivers age and our immune systems begin to fail, our thymus begins to involute. That whole combination add stress on top of that, that can definitely- we've seen triggering of autoimmune disease, which may or may not be directly attributable, but there may have been a predisposition where that additional stress added on top of it is the actual environmental trigger to activate that increased risk of cardiovascular disease. If you have those large glucose molecules bombarding the inside of blood vessels, we get all of that inflammatory process occurring. Atherosclerosis development is accelerated. Cardiovascular disease- cerebrovascular disease, sorry, also can become an issue. So we see increased risks of myocardial infarction or heart attacks and stroke occurring in these populations. Propensity for obesity and all of its manifestations, the development of sleep apnea and sleep cycles are interrupted, hypoxic events while you sleep. So you can see how this could easily start developing into a whole litany of adverse health outcomes for family caregivers and consequently, the importance of us helping people reframe negative perception into positive perceptions, ways to nourish that wellbeing, ways to help the intrinsic motivation, increased autonomy and connectedness and relatedness. All of those pieces become so integral to affecting an impact on those health outcomes that they're at great risk for.

R. Gleason: Thank you. The next question is what are one of the most reliable instruments to measure caregivers' health literacy level?

Dr. Sexson: Great question. So I actually have a resource list. So if you can share contact information with me, I am happy to send that out to you. There are a couple of tools that are

available for assessing caregiver health literacy. that would be really valuable for you to have the links to access those.

R. Gleason: Thank you. The next question is, are you able to provide information on the hospital process as it pertains to discharge planning when the patient and caregiver do not feel that the discharge is appropriate to home or a skilled nursing facility? I suppose they're asking what can be done about that.

Dr. Sexson: So from a policy perspective, I would look at the longterm services and support report card for your area because in there is an item for transitions in care, and it's a rating which is now being discussed as far as integrating into the reimbursement structure for hospitals. So looking at when have we actually unsafely discharged someone that's generally an unintentional event, but it does happen despite best efforts to discharge someone to a safe environment. Working with your organizations to really look at that I know in talking with folks across the country, there have been some really innovative thoughts about that particular event, the family conference with the providers and an institutional representative have been very helpful and that's something that we've had access to for years. Accessing your ethics committee when it is a question of patient autonomy versus safety, we allow people to make unsafe decisions all the time.

People smoke and we don't tell them they can't. We encourage them not to do that, but we don't necessarily punish them for doing that. So trying to figure out how to manage the ethical dilemma when there is that significant concern about safety in going home, your ethics committees can be really helpful. Some of the innovative pieces are folks when the education is an issue for caregiver or there's not a solid plan in place, actually discharging to what the last person I talked to about this turned a discharge reception area. So they've been discharged from the acute care setting to the discharge reception area where that final education with teach back whatever support services are needed to establish that a safe environment is available in whatever location you're going to, has been really quite novel and helpful for families. If people come back within

30 days of discharge from the hospital, that's all free care. The institutions don't get paid for that in Medicare population and Medicaid now. And so approaching from the standpoint of this isn't a safe discharge, they have a high risk of returning in less than 30 days. What can we do about that is sometimes a way to help navigate the system and of course, appealing to the insurance company when you have an unsafe discharge is also an important step.

This concludes the presentation.