<table>
<tr><td colspan="2">Example 1
Ms. Truong is a 53-year-old female with a history of hypercholesteremia and diabetes. She was at work when her co-worker noticed she had difficulty talking and fell to the floor as her right side collapsed. The co-worker called 911. Mrs. Truong was taken to the Emergency Department and diagnosed with an occlusion of the left MCA. Because she was on blood thinners, she was not a candidate for thrombolytic treatment. The stroke resulted in right sided hemiparesis, expressive aphasia and deficits in her executive function. She was transitioned from acute care to an inpatient rehabilitation facility for treatment and caregiver training. It was determined that she would need moderate assistance with mobility and self-care activities upon discharge. She is recently divorced and has 2 sons who live out of state. Fortunately, a long-time friend agreed to temporarily move in with Ms. Truong and assume the caregiver role. This friend's mother had a stroke and she was her caregiver so she had experience in the caregiver role. The Case Manager provided the friend with the PATH caregiver assessment. She appreciated that her needs were being considered as this was all so sudden. She really wanted to help her friend, but it was a lot with all of her other responsibilities.</td></tr>
<tr><td>Needs Identified in Caregiver Assessment: Items from the PATH Tool</td><td>Tailored Interventions</td></tr>
<tr><td>Friend has many other roles and responsibilities other than providing care for the patient (for example: work, volunteer work, childcare, pet care, meal preparation, laundry, home maintenance and yard work)?</td><td>Case Manager:
• Suggest caregiver brainstorm
1. A list of people who can help and
2. What responsibilities others can assist with.
• Educate on ways to recruit help and direct to Websites, e.g. CaringBridge or Sign Up Genius to coordinate assistance.
• Refer to respite information AARP: Caregiver Burnout: Steps for Coping in Stress</td></tr>
<tr><td>Friend concerned about her ability to continue providing care for the next year.</td><td>Case Manager:
• Review prognosis as described by the physician, emphasizing projected trajectory of recovery and decreasing dependence on caregiver.</td></tr>
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Facilitate creation of daily schedule for home. Include self-care activities.
Discuss factors to prevent caregiver burnout (support system, self-care, life balance, leisure/social interaction, etc.)

Occupational Therapist:

Discuss positive lifestyle modifications to promote CG health and wellness
Discuss leisure and self-care activities pt could perform individually and as dyad

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<td colspan="2">Results: Mrs. Truong went home with the assistance of her friend who was able to recruit help from Mrs. Truong’s co-workers and their walking group. They created a regular schedule on CaringBridge for caregiver respite for the friend to engage in her other responsibilities, in addition to assistance with instrumental activities of daily living. Follow-up after 30 days indicated that the caregiver was able to manage in the caregiving role with the assistance of others. Mrs. Truong had improved and only needed minimal help. The friend moved in and they once again enjoyed leisure activities together.</td>
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Example 2 Mr. Garcia is an 86-year-old male with past medical history significant for diabetes, diabetic peripheral neuropathy, HTN, bladder cancer, and basal cell skin cancer who was in his usual state of fair health until he sustained a mechanical fall. He tripped over his walker on the way to answer the door and tumbled over the front of the walker, landing on the right side of his face. Mr. Garcia thinks he may have blacked out for a few minutes. He blames the fall on poor sensation/balance from his diabetic peripheral neuropathy. Mr. Garcia was unable to get up after the fall as he sustained a C2 – ASIA D spinal cord injury. This resulted in tetraplegia, neurogenic bowel, and associated functional deficits. He was transferred from the trauma hospital to an inpatient rehabilitation facility for rehabilitation and caregiver training. His elderly wife and recently retired daughter will provide caregiving support. Mrs. Garcia has her own health issues with chronic back pain and COPD. Both Mrs. Garcia and her daughter express feelings of being overwhelmed. They completed the PATH caregiver self-assessment which conveyed many areas of concern. The survey results were shared with the Case Manager and medical team via the electronic medical record.	
Needs Identified in Caregiver Assessment	**Tailored Interventions**
Lack of understanding of the patients' recovery over the next 6 months	MD: • Discuss medical and functional prognoses
Lack of understanding about home preparation and discharge planning	Case Manager: • Educate regarding the roles of team members (home set-up and accessibility, equipment, medications, bowel & bladder management, mobility, transportation, follow up and continued therapy.
Lack of understanding about what assistance the patient will need with personal care (such as bathing, using the toilet, dressing and moving around).	Therapy (PT, OT, &ST): • Discuss deficits and functional limitations. • Utilize teaching strategies to optimize caregiver skill-building using simulation (e.g. using the teach-back method) (AHRQ, 2020a). • Utilize resources such as the Patient Education Materials Assessment Tool (PEMAT) to ensure readability of materials provided to the caregiver (AHRQ, 2020b).
Lack of caregiving experience	Case Manager: • Assist the caregiver to schedule their time during rehab so they can be present for observing care and attend to self-care and other required personal activities/ commitments (e.g. outstanding physician visits and other personal needs/obligations) • Provide educational resources for caregiver support. (e.g. Caregivers Alliance, Area

	Agency on Aging, Christopher Reeves Foundation)
Health problems (e.g. difficulty bending or stooping, back or joint problems, heart issues, memory, depression, anxiety or other health challenges)	Who? Case Manager? • Discuss feasibility of Mrs. Garcia helping with physical care. • Explore alternatives and identify activities where she can be of assistance.
Lack of willingness to provide personal care (such as bathing, using the toilet, dressing and moving around)	Case Manager: • Explore why the caregiver may be reluctant to provide personal care. • Explore alternative caregiving options such as hired care or alternate living arrangements options (e.g. B&C, ALF)
Lack of friends, social support or family who may be able to assist with patients' personal care or other responsibilities, such as yard work, pet care, meal preparation, laundry, home maintenance	Case Manager: • Assist with the creation of a calendar to clearly identify the dates/times that caregiving help is needed. • Discuss and provide resources (e.g., CaringBridge, Meals on Wheels and Meal Train).
Lack of financial resources to pay for needs not paid for by insurance, SSI, Workers Compensation, IHSS or other benefits	Social Worker or Case Manager • Provide education on timeline of public funding, low-income pharmacy, free equipment, charity care program, Craig's list, DME closet in church or community. • Provide and review handout of financial assistance resources (e.g. National Council on Aging – Free Benefits check-up service, State Health Insurance Assistance Program (SHIP). • Explore eligibility for financial resources through the Veterans Administration.
Lack of accessible transportation	Social Worker or Case Manager: • Assist with Paratransit application. • Educate and assist with DMV Application.
Results: Mr. Garcia was discharged to his home in the care of his daughter and a hired caregiver with follow up therapy via Home Health after a 17-day length of IRF stay. Mrs. Garcia realized she could not provide physical assistance due to her own health conditions. Reassessment in 30 days indicates Mr. Garcia's caregivers need assistance activating resources; assistance provided by primary care case manager.	

Example 3	
Mr. Jones is a 72-year-old man who has recent onset dementia. Recently, he fell and fractured his hip. He had a 3-day acute care stay during which he had a hip replacement. Mr. Jones was transferred to a skilled nursing facility (SNF) for ongoing rehabilitation. During the stay it was determined that Mr. Jones was not able to return to his home due to his care needs and his cognitive deficits. The facility had a family meeting and it was determined Mr. Jones would be discharged to the home of his son with care provided by his daughter-in-law, Gina. Mr. Jones and Gina have had longstanding strain in their relationship, however no alternative discharge disposition was feasible. During the SNF stay, the daughter-in-law was provided with the PATH instrument to complete.	
Needs Identified in Caregiver Assessment	**Tailored Interventions**
Concern about ability to sustain the caregiving role long-term	Case Manager or Social Worker?: • Refer to resources for supporting caregivers of persons with dementia such as AARP *Tips for Coping with Stress* (https://www.aarp.org/caregiving/life-balance/info-2019/caregiver-stress-burnout.html?intcmp=AE-CAR-BAS-IL) and other caregiver resources available at AARP and Alzheimer's Association.
Conflict in the relationship	Case Manager or Social Worker: • Suggest counselling for Gina and her husband on ways to co-manage the relationship between Mr. Jones and Gina while he is living in their home. Provide referral. • Provide resources on mindfulness for Gina. • Provide education on dementia and strategies to minimize conflict. • Utilize teaching strategies to optimize caregiver skill-building using simulation (e.g. using the teach-back method) (AHRQ, 2020a Nov.). • Utilize resources such as the Patient Education Materials Assessment Tool (PEMAT) to ensure readability of materials provided to the caregiver (AHRQ, 2020b Nov.).

Results: Mr. Jones received home health therapies for three weeks and was discharged to outpatient therapies. At 30-day follow up it was identified that Gina needed additional mental health coaching to sustain in the caregiving role. She was referred for mental health coaching and connected to a support group for caregivers of people living with dementia for emotional support.