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Ensuring Effective Care Transitions: The Role of Home Infusion

BY LINDA MCBRIDE, MS, RN

E ffective care transitions play a critical part in appropriate healthcare resource utilization and positive clinical, economic and patient satisfaction outcomes. Thoughtful, well-planned care transitions can help reduce length of stay (LOS), prevent rehospitalization, and avoid visits to the emergency department, saving healthcare dollars, increasing hospital efficiency, and helping to improve patient outcomes.

Successful care transition is a multidisciplinary, patient-centered process that, among other factors, considers appropriate site of care. One particular site of care – the home – can be an important option for supporting effective care transitions, and home infusion can play a key role in that effort.

Transition from the hospital to home starts with pre-discharge planning, which determines the patient and family’s specific needs for discharge, and it continues with ongoing care after discharge. Coram has found that supporting these two stages of care transition through thorough assessments, comprehensive patient education, and ongoing communication helps enable both speed of transition and positive patient outcomes.

PRE-DISCHARGE PLANNING

A safe, effective transition from the hospital to home begins at the time of admission.

Management of pre-discharge transition activities: The complexity of many care transitions requires a high level of communication to prevent gaps in care. To help ensure successful implementation of the transition plan, Coram employs clinical service liaisons (CSLS).

From the time of admission through discharge, the CSL’s function is to provide seamless communication and coordination of home infusion and other services between the hospital case manager, treating physician, health plan medical management team, patient, and members of the infusion clinical team. For instance, the CSL can consult with the clinical team regarding the appropriateness of home infusion therapy for patients, as well as where pumps are needed, dosing frequency, line access needs, and other matters, based on the patient’s unique situation. The CSL can also assist in coordinating the patient’s discharge with the hospital case manager, the medical group, the treating physician, and other hospital staff as appropriate. Having the CSL serve as a single point of contact for the patient’s other care providers can help ensure that transitions are as seamless and comfortable as possible for the patient.

Diagnosis flagging: This is a key step of the process – identifying the patient who will likely require infusion services and benefit from receiving treatment in the home setting. Numerous disease states lend themselves to consideration for home infusion, and diagnosis flagging for these conditions upon admission enables early home infusion candidacy assessment.

Our CSL is contacted when a patient is flagged as a potential Coram home infusion candidate. He or she initiates the patient’s candidacy assessment and relevant care planning. This early planning helps keep the transition process on track for timely discharge.

Patient assessment: To best appreciate the patient’s own situation and needs, a thorough patient assessment is needed. This is a key step, as each patient and family situation is unique and must be addressed as such.

Once a potential candidate has been identified, Coram staff conduct a patient interview. Information from this patient interview – about demographics, psychosocial status, and clinical needs – provides the foundation for individualized patient planning and transition coordination. This helps prevent challenges later in the transition-planning process, which can interrupt and often delay timely transition.

Pre-discharge education: Patient education, provided before the patient is discharged, is critical to promoting patient compliance. Pre-discharge education is essential not only as part of the provider’s obligation for informed consent, but also to further identify and address patient-specific challenges.

Before a Coram patient goes home, we provide education to the patient and/or caregiver regarding the scope of services provided by the infusion team and what the patient should expect when they arrive home. The Coram CSL provides education that incorporates hands-on teaching, leave-behind materials, and references for relevant patient resources, such as support groups. Our education plan includes teaching the patient and their caregiver how to take an active role in their care in order to achieve independence in therapy administration. With the clear goal of avoiding unnecessary hospital readmissions from emergency department visits, patients are instructed on signs and symptoms to report to either the physician or home infusion team. Return demonstration (having the patient “teach back” what he or she has learned) helps assess and ensure patient understanding and capability.

Insurance verification: An often time-consuming challenge in the transition process is verifying insurance benefits, including the patient’s covered benefits and their financial responsibility for the prescribed therapy and/or services. Insufficient insurance coverage is a significant obstacle for timely discharge, as can be the patient’s own ability to meet their often high deductibles and/or copays.

Coram’s clinical and reimbursement specialists work with health plans to confirm benefits and clarify patient payment responsibilities. These individuals are required to have an in-depth knowledge of reimbursement issues in order to resolve verification issues quickly, subsequently speeding up the discharge process.

POST-DISCHARGE TRANSITIONS OF CARE

The effective transition process continues after the patient arrives home.

Complex patient management: Many home infusion candidates have multiple illnesses, are on multiple therapies, or require medications with potential for significant adverse effects.

Coram home infusion pharmacists are a critical resource for managing these complex patients. They work with the patient’s physician to help create a therapy care plan and...
ways to deliver it based on the patient’s clinical status, medical history, environmental realities, and ongoing response to therapy.

Post-discharge and ongoing patient education: Ensuring continued patient compliance with the care plan requires effective patient/caregiver education that addresses disease, drug and equipment, and each patient’s individual learning style. While the Coram CSL initiates patient education prior to discharge, the patient’s primary home infusion nurse continues the process in the home.

Ongoing communication and support: Ongoing communication with and support of a patient at home enables early identification of actual or potential problems. These problems can then be addressed before the patient requires a hospital admission or emergency department visit.

Follow-up and clinical monitoring in the home by our registered nurse and other clinical team members, such as a pharmacist and dietitian, as well as 24/7 access to these care providers, helps sustain the transition and keep the patient at home and recovering.

Ongoing communication with the patient’s physician and the hospital is also key to ensuring continuity of care. At Coram, we inform the hospital when the patient is home and successfully on therapy, and we provide the referring physician with ongoing patient updates. As the “eyes and ears” in the patient’s home, our local clinical team continually gauges the patient’s adherence to the care plan and response to therapy and communicates back to the physician, allowing therapy to be adjusted as needed.

CONCLUSION
Home infusion providers can do much to ensure effective care transitions for their patients. At Coram, we have found that smooth, timely and sustained care transitions are a key part of providing a safe, positive, and effective experience for our patients. The policies and procedures we have implemented to help ensure such transitions enable patients to enjoy shortened lengths of stay, reduced rehospitalizations, and fewer visits to the emergency department. These results not only save healthcare dollars and help improve clinical outcomes, they improve the therapy experience for our patients.

REFERENCES

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Securing Community-Based Care Transitions for Pediatric Patients

BY DEBBIE HEINECKE, RN, MSN

Children and young adults with special healthcare needs often have frequent hospitalizations and are discharged home with ever-increasing medical and technology dependencies. Hospital discharges of these children can be a complex and multi-step process. Pediatric care coordinators must develop a plan that includes a transitional care program that addresses the child’s ongoing healthcare needs as well as educational, spiritual and psychosocial needs. This plan must also encompass the caregiver/family’s issues so they will be able to support the child and his/her care needs at home.

An integral part of the plan is the medical home, which is a collaboration between the child, the family and the physician in partnership with the child’s medical specialists and community service providers. This includes all aspects of care, including medical, behavioral, cultural and spiritual needs of both the child and the family. A medical home ensures that there is accessible, coordinated, comprehensive, compassionate and culturally-sensitive care to provide the optimal opportunities for the child’s growth and development.

EVALUATION AND ASSESSMENT
A key aspect of transitioning from hospital to home is evaluating the child’s parent/caregiver’s knowledge and skills in providing the care the child will need at home. Training is often necessary if there are new medications, equipment and/or procedures that must be done when the child is home. The care coordinator must establish a strategy of training for the caregiver to include information on medications and administration procedures, equipment functioning and troubleshooting, and performing necessary therapies and procedures. The caregiver must also be provided the opportunity to demonstrate their skills and knowledge of this care. Both the family/caregiver and the medical staff must feel comfortable with the caregiver’s proficiency level before the child is discharged to home.

The family’s psychological readiness must also be assessed to ensure that they are prepared to manage the post-hospital care needed by the child. If the caregivers are stressed, feel incompetent or do not feel knowledgeable in providing this care, this may cause a multitude of problems, including personal and family conflicts, as well as frequent rehospitalizations. In addition, issues such as losing work, escalating expenses, and adequate time for the other children may cause an increased burden on the family. Additional community services like financial assistance may be needed prior to the child’s discharge to home.