Home infusion professionals play an important role in assuring successful care transitions from hospital to home. To assist during these crucial changes in care settings, The Joint Commission has assembled a variety of resources for patients and providers alike. As part of that effort, we have identified seven foundations for safe, quality transitions of care (see the box on this page). By relating these foundations to home infusion therapy, practitioners can help patients achieve optimal health outcomes. This article offers an introduction to each through the lens of providers within your own community. For a 30,000-foot view of the importance of care transitions and effects to improve them across the health care industry see, “Crossing the Divide—Investigating Successful Care Transitions” on p. 20.

Seven Foundations for Safe, Quality Transitions of Care

- Leadership support
- Multidisciplinary collaboration
- Early identification of those at risk
- Transitional planning
- Medication management
- Patient and family engagement
- Transfer of information

Source: The Joint Commission

Leadership Support

The National Home Infusion Association, The Joint Commission, and other leading organizations have been working together to improve transitions from hospital to home infusion care. Your organization can tap into the many resources developed on this topic to gain your leadership’s buy-in of efforts to continually improve processes and performance relating to home infusion therapy.

Gaining leadership support is the first of the seven foundations because it positions home infusion care quality improvement among the strategic goals set at the health system level. It is crucial to define clearly how improved transitions to home infusion care can help reach system-wide goals, such as decreasing readmissions and emergency visits, reducing infection rates, and improving patient satisfaction—all of which are essential to financial success as value-based payments emerge.

Creating a culture that enables the development of quality improvement processes is a key component of strong leadership support. For example, The Baptist Memorial Healthcare System of Memphis encourages the sharing and “hard-wiring” of successful processes throughout the system, says Tony Powers, PharmD, the CEO of Medical Alternatives, a home infusion pharmacy affiliated with the system. Using quality improvement activities, the system has identified highly dependable processes relating to care transitions that it passes along to all its members.
Melissa Leone, Manager of Infusion Care Nursing Operations for Coram CVS/specialty infusion services, says her organization continually reviews and incorporates best practices.

“We stay very involved and very present in national meetings,” she explains. “We incorporate literature standards that are available in the industry. Whatever tools that are available out there that will help us achieve a more successful outcome for the patient, we are absolutely taking advantage of them.”

Leadership support is particularly important toward setting an organizational culture of multidisciplinary collaboration. To strengthen this message, the Joint Commission developed five case examples that illustrate the essential role of multidisciplinary teams in achieving optimal outcomes for patients cared for in the home setting.¹

One of these examples involved the Cleveland Clinic Center for Connected Care Infusion Pharmacy at Home, which works closely with the clinic’s onsite Medicare-certified home care agency and other health care team members to educate the patient before discharge and to monitor the progress of the patient in the home setting. The team reduced 30-day readmissions of patients receiving parental antibiotic therapy via peripherally inserted central catheter (PICC) lines by 7% over a year’s time. For higher-risk patients with central lines inserted through the chest, the team reduced readmissions by 23% in a year’s time.¹

Assessing the patient’s readiness and ability to engage in self-care is a critical determinant of potential success. According to Coram’s Leone, making this determination often requires input from many members of the multidisciplinary team, including the patient and family, and incorporates an assessment of patient and family caregiver capabilities and whether or not they will be able to administer the medications they require. Prior to discharge, to help facilitate the care transition, “we’re looking to educate the patient and the caregiver on what is expected of them in the home setting to ensure that they’re on board with that and agreeable to that,” explains Leone.

Multidisciplinary care helps to identify and reduce risks, the third pillar of the seven foundations. Once risks are identified, planning for a care transition can be attuned more precisely to a patient’s needs.

Home infusion pharmacy Medical Alternatives searches through patient outcomes data for indicators, such as hospital readmissions and infections, and then drills down to identify high-risk patients. “It’s collecting data, stratifying results, and getting all the players involved that makes the difference,” Powers says. “We’re beginning to recognize select high-risk situations where extra effort on our part can make a difference in the outcomes achieved.”

In select cases, Medical Alternatives sends its nurses to the hospital pre-discharge to do training, focusing particularly on high-risk patients such as those needing complex therapy involving more than one medication, and patients meeting other guidelines. Once the patient is at home and “when the nurse from the nursing agency comes, it’s not the first time that the patient has been exposed to the therapy, infusion techniques, and the infusion pump,” Powers explains. “This helps alleviate patient anxiety, and the patient is less likely to need readmission or a trip to the emergency department.”

The team’s risk assessment comes to bear directly on transitional planning, which requires engagement from all team members, including the patient and caregivers.

The Medical Alternatives team attends hospital staff meetings weekly to identify patients who are having difficulty transitioning to discharge. Also participating in these meetings are social workers and representatives from home health, medical equipment and rehabilitation. Together, they identify the barriers to transition and determine the next steps and most appropriate environment of care for that patient. “This team approach works very, very well for us,” Powers asserts.

Patients benefit greatly from a review of the plan of care before discharge. Powers continues. “Regardless of their therapy, age, or anything, all patients get a callback within 72 hours of admission just to go over everything again,” Powers explains. “It is common for patients receiving care from multiple home care companies to be confused on the companies’ services, responsibilities, and their participation in care.” Medical Alternatives also greatly emphasizes aseptic technique and hand-washing, as well as 24/7 on-call availability. “If everything is done correctly on the front end and the patient is successful within the first four days of therapy, they usually do well. If you don’t do those things correctly on the front, you will commonly have problems,” Powers observes.

At this stage, home infusion professionals have a broad range of responsibilities beginning in the inpatient setting and continuing at the home. Before discharge, the focus is on education about infusion therapy. At the Cleveland Clinic, a multidisciplinary team including the infusion pharmacy team provides education within the inpatient setting about how to manage and administer medications and how to operate infusion equipment, using materials with step-by-step instructions and places to write notes. Team members use teach-back methods to create understanding and competence about issues such as medication administration and possible risks such as dehydration, weight gain, and water retention. Follow-up occurs through on-call services and home visits if necessary.¹

In the home setting, infusion care professionals can work with other care team members to make the patient’s medication profile consistent among providers and electronic
If you think of health care as a relay race, patient transitions are the points at which the baton is passed from one teammate to another. When the patient moves from one site of care—one care team—to another, a poor handoff can be detrimental. Successful relay teams must exhibit trust and confidence in the “exchange zone” or risk being disqualified by a bad pass.

Unfortunately, our fragmented health care system is fraught with these exchange zones, each of which can potentially expose patients to harm. In 2001, the Institutes for Medicine (IOM) pointed out in its report, Crossing the Quality Chasm, U.S. health care is distinguished by “layers of processes and handoffs that patients and families find bewildering and clinicians view as wasteful.” Despite an elevated awareness of how important patient transitions are to both clinical outcomes and costs, there is still room for improvement today.

In 2011, researchers estimated that poor care coordination, including inadequate management of care transitions, was responsible for $25 - $45 billion in avoidable complications and unnecessary hospital readmissions.1 Not surprisingly, seniors and patients with multiple, chronic conditions are the most likely to experience these events. According to the Centers for Medicare & Medicaid Services (CMS), approximately 2.6 million seniors are readmitted to the hospital within 30 days, at a cost of over $26 billion every year.2

Over the past decade or so, health policy experts have taken numerous steps to reduce errors, readmissions, and waste that can result from poor care transitions. The majority of those efforts have focused on improving care coordination. Some programs have carved out new roles, such as transition coaches or medical homes, that quarterback care. Others have restructured payments based on outcomes to motivate providers across care settings to work together.

The Affordable Care Act (ACA) was chock-full of provisions, including both carrots (hospital payments for meeting and exceeding performance targets) and sticks (reduced payments for readmissions). By creating the Center for Medicare & Medicaid Innovation (CMMI), the ACA also funded several demonstration projects to test various care coordination models. CMMI pilots now cover payments for care coordination services conducted through medical homes, comprehensive primary care, and community-based organizations.

The ACA also created mechanisms to shift Medicare reimbursements into new models, such as accountable care organizations (ACOs) and bundled payments, that also emphasize care coordination across the continuum. This April, hospitals in 67 metropolitan statistical areas (MSAs) will see the latest of those initiatives as bundled payments for joint replacement go into effect. CMS asserts that, “This model will hold hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries for hip and knee replacements and/or other major leg procedures from surgery through recovery.”3

Payment and policy initiatives have set the stage for improving patient transitions, but they don’t always fill in the details about why poor handoffs occur in the first place and which practices go into quality care coordination. Fortunately, extensive research has been done in this area as well. The National Quality Forum (NQF), the consensus-driven arbiter of quality in health care, defines care coordination as “a function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time.” NQF identifies five domains essential to the future measurement of care coordination, including health care home; proactive plan of care and follow-up; communication; information systems; and transitions or handoffs.4

Other groups, such as the National Transitions of Care Coalition and the Alliance for Home Health Quality and Innovation, have similarly identified critical aspects to improved care coordination and created their own evidence-based transitions of care models. Each list is slightly different, but a few common threads emerge. The key elements involve patient and family engagement and coaching, multi-disciplinary collaboration with accountability at each step, simplified and fluid exchange of health information, a clear care plan, and timely follow-up from all involved. Communication is key, especially in the area of medication reconciliation, which is consistently identified as a critical step in every transition. And, of course, electronic medical records, standardized documents and tools, quality measurement and tracking, and reimbursement incentives are typically invoked as requirements for successful adoption.

Given our long history, providers working in the home site of care are well positioned to facilitate—and lead—successful care transitions, but are not often recognized as being a critical partner in managing these transitions. Feeling that the dearth of models that include the home setting was partly responsible for this omission, the Alliance for Home Health Quality and Innovation (AHHQI) undertook a wide-ranging effort to identify...
the steps home health providers should take to improve the patient care experience and health outcomes during transitions from hospital to home health care. The result is a comprehensive toolkit for home health nursing providers. While it is not entirely transferable to home and specialty infusion, AHHQI’s model includes a first visit checklist that should be familiar to clinicians in our field:

- **Patient assessment.** A comprehensive assessment, including any barriers to care, the need to bring in other disciplines, and the patient’s baseline health literacy.
- **Patient education.** How to reach a clinician after hours, advanced directives, personal health record, plan of care and frequency of visits, and red flags for symptom recognition.
- **Follow up coordination of care.** Medication reconciliation, reporting back to referral source, and follow up appointments.

Also interested in improving patient transitions, regulating and accrediting bodies are working to create best practices and describe steps required of providers under their purview. These groups are able to drill down to customize the many core elements described throughout the various models on the continuum for a specific provider group. In the accompanying article, “Home Infusion Professionals Play Essential Role in Successful Transitions to Home Care,” Margherita Labson, Executive Director of the Joint Commission’s Home Care Accreditation Program, explains what her organization has identified as the seven foundations for safe, quality transitions of care. Distilled from best practices in other health care settings, these seven foundations provide a strong blueprint for home and specialty infusion providers regardless of their accreditation status.

### References

eter-days, despite their patients being very ill and having complex catheter treatments.\(^1\) A national study of pediatric CLABSI rates within home health care agencies associated with children’s hematology/oncology centers found a mean CLABSI rate of 0.54 per 1,000 catheter-days.\(^1\)

**Transfer of Information**

As health care organizations begin to use more sophisticated methods of electronic communication, the transfer of information is facilitated but still must be closely monitored and updated. Beyond the simple electronic or fax transmission of records, it’s important to have personal conversations and collaboration between the sender and receiver prior to the transition. At this time, patient needs, patient education, the reason for the transfer or discharge, and a summary of care and progress can be discussed.

Common tools used during this transfer of information are SBAR (Situation, Background, Assessment, Recommendation)—a best practice for standardized communication.\(^4\) The Institute for Healthcare Improvement has a SBAR Toolkit that includes templates for easy use and adaption.\(^3\) The state of New Jersey has developed a universal transfer form that all licensed health care facilities there are required to use.\(^6\) In addition, many organizations employ a liaison nurse for the express purpose of making care transition as personal and smooth as possible.

The Joint Commission has created a Targeted Solutions Tool\(^+\) (TST) for hand-off communications. The TST guides organizations through a step-by-step process to measure hand-off communication performance, identify barriers to excellent performance, and direct organizations to proven solutions that are customized to address the barriers.\(^7\)

Developing interoperable electronic records systems also aids the transfer of information. Medical Alternatives has access to the Epic-based health information technology (IT) system being employed by the Baptist Memorial Healthcare System. The pharmacy receives notice of referrals or potential patients via electronic e-mails sent through the IT system. “When we document back into the Epic system, that documentation is read by case managers, nurses on the floor, social workers, and physicians,” Powers says. “Most of the physicians have tablets or smartphones and so we can constantly communicate with them about things that need to be done prior to discharge, barriers that we see, and when the patient is ready for discharge from the hospital.”

**Summary**

By reviewing best practices relating to these seven foundations of safe, quality transitions of care, home infusion professionals can find effective ways to improve quality performance and patient outcomes.\(^\text{ni}\)

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References


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