

# Collaboration of Hospital Case Managers and Home Care Liaisons When Transitioning Patients

Margaret M. Kelly, BSN, RN, and Erika D. Penney, MSN, RN, CPNP, CCM

## ABSTRACT

**Purpose/Objectives:** Hospital case managers frequently collaborate with home care liaisons when coordinating special discharge plans. This article focuses on the collaborative relationship between the hospital case manager and on-site liaison whose primary role centers around care coordination and patient teaching. Ineffective collaboration between hospital case managers and these clinical on-site liaisons can lead to serious lapses in care and services for patients, families, and the health care team when transitioning from hospital to home care. In a review of literature, little detail was found about the collaborative practice between hospital case managers and home care liaisons. This article discusses how collegiality, collaboration, and role clarification between hospital case managers and on-site home care liaisons can improve coordination of care and services for patients and their families in the transition from hospital to home care. Included is a set of guidelines developed by case managers at a major metropolitan acute care hospital to inform and improve their practice with home care liaisons.

**Primary Practice Setting:** The authors are nursing case managers who practice in a major metropolitan teaching hospital. They met by telephone and in person with case managers from 3 metropolitan medical centers as well as on-site liaisons from 2 skilled nursing facilities and 5 home care agencies to develop practice recommendations for their department regarding work with home care liaisons.

**Findings/Conclusions:** Conversations between hospital case managers and on-site home care liaisons revealed that all had experiences in which suboptimal collaboration negatively impacted home care coordination for patients and their families. Furthermore, outcomes in similar patient scenarios varied widely based on the individual practices of the case managers and liaisons involved in discharge coordination. Multiple issues were discussed, including blurred role and responsibility delineations, variations in communication styles and practices, and different levels of experience and training. Consensus regarding the implementation of the hospital's guidelines was achieved through a series of discussions within the workgroup in developing practice guidelines. Multiple revisions and secondary reviews by colleagues and directors took place before the guidelines were accepted and implemented.

**Implications for Case Management Practice:** Recommendations for improving collaboration with liaisons included (1) taking time to become familiar with one another's practices and backgrounds; (2) ensuring clear discussions of roles, responsibilities, and expectations with liaisons related to individual cases and organizational requirements and limitations; (3) providing time and forums for ongoing communication and follow-up; and (4) recognizing that responsibility for certain aspects of the discharge planning process may be shared but that the case manager, in partnership with the multidisciplinary team, is ultimately accountable for the effectiveness and outcomes of the discharge plan.

**Key words:** *collaboration, care transitions, discharge planning, guidelines, home care liaison, hospital case management*

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Address correspondence to Margaret M. Kelly, BSN, RN, Case Management Center, Children's Hospital Boston, 300 Longwood Avenue, Boston, MA 02115 (Margaret.Kelly@childrens.harvard.edu).

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**H**ospital case managers frequently collaborate with home care liaisons when coordinating discharge arrangements for patients and families. In some cases, the liaisons are licensed professionals who work on-site at hospitals to gather information and provide necessary transitional care services for patients requiring varying levels of clinical care. In other cases, liaisons are unlicensed representatives of home care agencies whose responsibilities range from collection of demographics and insurance information to making on-site visits for home equipment deliveries and teaching. This article focuses on the collaborative relationship between hospital case managers and licensed hospital-based home care liaisons who provide a clinical component to discharge preparations. Liaisons who work onsite at an acute facility are much more involved with the discharge planning team than liaisons who operate from remote locations. These on-site liaisons can play a vital role in patient/family education, problem solving, and ensuring that their agencies receive all the necessary information and documentation to provide timely and quality care at home.

Effective collaboration between the hospital case manager and on-site liaisons is essential for well-coordinated discharge plans and optimal management of patient/family insurance benefits and health care resources. Potential ramifications of ineffective collaboration are numerous, including compromise of the patient's clinical condition, gaps in timely service provision, omissions in deliveries of home care supplies and equipment, incomplete patient/family preparations, added care burden for postdischarge health care providers, worry and anxiety for the patient and family, and unanticipated patient/family financial responsibilities. It is "an essential responsibility of case managers to optimize patient safety by promoting clear and concise transfer of information during transitions and hand-offs of care" (Carr, 2007, p. 71). Likewise, "planning for these transitions can contribute significantly to a person's future quality of life" (Carroll & Dowling, 2007, p. 882).

With an eye to improving transitions from hospital to home and clinical outcomes, a group of case managers at one metropolitan hospital developed guidelines in collaboration with home care liaisons. In this hospital, all on-site liaisons are sponsored by the director of the case management program. Liaisons undergo hospital credentialing procedures and orientation to policies and procedures including those for protection of patient confidentiality and prohibiting marketing activities on clinical units. They are granted limited access to charts only for patients for whom they have received formal referrals from the hospital case managers. Likewise, they are authorized to interact with members of the interdisciplinary team for purposes directly related to the services they are arranging

for these patients. Such interactions range from providing guidance to clinical staff regarding what prescriptions and documentation are necessary to participating in clinical discussions with team members about patient/family needs and progress in discharge preparations. In these cases, they are authorized to meet with patients and their families to discuss their services, assess needs, provide teaching regarding home equipment, and offer anticipatory guidance to families regarding home care preparations.

Development of the guidelines began with conversations between case managers and liaisons at several metropolitan hospitals that revealed that all had experiences in which suboptimal collaboration negatively impacted home care coordination for patients and their families. Outcomes in similar suboptimal patient scenarios varied widely based on the individual practices of the case managers and liaisons involved in discharge coordination. Multiple contributing factors were discussed, including blurred role and responsibility delineations, variations in communication styles and practices, and different levels of experience and training. This article discusses how collegiality, collaboration, and role clarification between hospital case managers and on-site home care liaisons can improve coordination of care and services for patients and their families and avert potential stumbling blocks in the transition from hospital to home care. Included are an overview of the background discussions that contributed to the guideline development and the set of guidelines that was developed by the case management group.

## **IMPETUS FOR PROJECT**

The impetus for this project came from discussions with seasoned case managers from several adult and pediatric acute care facilities as well as liaisons from skilled nursing facilities and home care agencies regarding their collaborative experiences in the discharge planning process. Two composite cases illustrate scenarios familiar to many of the participants in which the transition to home care was less than smooth.

In the first case, an infant with tracheomalacia was discharged home with a tracheostomy and gastrostomy.

*Case managers and liaisons agreed that problematic discharge planning coordination often was due to breakdowns in communication and incorrect assumptions about responsibilities and accountability.*

*The workgroup observed that the area of shared responsibility can potentially present the most pitfalls for discharge plans if clear communication relative to responsibilities does not occur.*

Before the birth of their infant, the family had no prior experience with the care of a child with special needs. They lived in a state far from the hospital and their discharge needs were complex, requiring a comprehensive, multifaceted plan. The case manager discussed options for home care providers with the family and secured consent for referrals to the providers that the families had selected for their child's care. One referral was made to a home equipment company with branches locally and in the family's state. Once the on-site liaison had determined that her company was contracted with the family's insurance and could provide services in both states, the liaison was given access to the patient's record by the hospital case manager and permission to meet with members of the patient's multidisciplinary team. The liaison provided teaching to the family regarding use of home equipment and supplies, including a suction machine, mist unit, enteral pump, tracheostomy care supplies, Ambu bag, and gastrostomy supplies. This teaching supplemented the essential discharge teaching provided by the family's nurses, physicians, and other members of the health care team.

The liaison also ensured that all the supplies and equipment needed for travel were delivered before the discharge. The liaison asked her local branch to facilitate home delivery of the rest of the supplies and equipment by the branch in the family's home state. The case manager spoke with the liaison to ensure that arrangements had been made. However, when the parents arrived home, they found that the local branch had delivered incorrect supplies, including adult-sized suction catheters, mist collars, and Ambu bag. They also received feeding bags that did not adapt to the enteral feeding pump on which they had been instructed. When the family called the number they had been given for the local branch, they were told that there was no record of their child's services. It took many calls to sort out the confusion and ensure that the parents had what they needed to care for their infant. Needless to say, this created additional stress and care burden for the family and could have led to gaps in the child's care without prompt intervention.

In follow-up, the case manager and home care liaison both acknowledged that neither had personally made a call to the branch that would be providing the

supplies and equipment in the family's home state. Likewise, they had not established a plan to double check that the family had received all the correct supplies and equipment before discharge. Either of them could have completed these tasks had their follow-through been more thorough.

In the second scenario, an adult patient with osteomyelitis was being discharged home on intravenous antibiotics. The case manager met with the patient to discuss options for home infusion providers. After informed consent was obtained, the case manager initiated a referral to a home infusion agency that was contracted with this patient's health plan. The on-site liaison nurse from this company was granted access to the patient's record and health care team. She provided all essential clinical, demographic, and insurance information to her home care associates before meeting with the family. During this time, her associates informed her that another referral would be necessary to a visiting nurse agency (VNA) that could provide the infusion visits in the home. This patient's particular insurance plan did not contract with any infusion companies for home nursing services. However, her agency would be able to provide all intravenous medications, supplies, and equipment. Also, their contract would cover her initial hospital teaching to the patient and family regarding how to deliver antibiotics intravenously using the company's equipment and supplies. The liaison shared this information with the case manager.

The case manager checked with the patient's insurer and verified the details of the home infusion benefit. The case manager then met with the patient and his family to discuss the additional referral that was necessary to ensure a safe and appropriate home care plan. She provided the family with a formal list of agencies that could provide services at their home. After informed patient choice was obtained, a referral was made to a contracted VNA for the home infusion nursing visits. Because this agency had no on-site liaison, the nurse case manager informed the VNA intake personnel of the patient's current clinical status, home care plan, contact information for the home infusion agency, and anticipated date and time for the first visit at home, which was needed on the evening of discharge. She asked the home infusion liaison to ensure that the VNA had necessary information on the equipment and supplies that would be sent into the home.

Before discharge, the on-site infusion liaison provided initial teaching to the patient and his family in use of the infusion pump and on how to administer the medications and flushes. She also made arrangements for the medications and supplies to be delivered to the patient's residence in time for the first scheduled dose at home. Unfortunately, neither the hospital case manager nor the on-site liaison made a final call to the VNA to confirm the discharge; nor did the VNA call the case

*This team includes the multidisciplinary hospital care team, the patient and family, and other community providers and (all) have accountability to the ultimate success of the transition to home care services. The contributions enhance the effectiveness of the discharge planning process and ultimate care and services to the patient and family. In short, they are partners in many aspects of discharge planning and coordination.*

manager to confirm that the originally communicated plan was still in place. As a result, the patient and family received no nursing support for the first home dose in the evening. The VNA did not call the patient until the following morning after its intake personnel found the patient care referral on the fax machine. Fortunately, the patient and his family were able to complete the scheduled infusions on the basis of teaching in the hospital. However, they had been told that a nurse would be there to supervise them for their first dose at home. Understandably, they were quite upset about the gap in services and found the transition to home much more stressful than they had anticipated.

In review of this incident, the case manager and liaison acknowledged that they had each made an assumption that the other had made the final call to the VNA confirming discharge. Likewise, the VNA intake nurses informed the case manager that they were waiting for this call before finalizing their arrangements. Simple clarification of who would communicate with all providers regarding the discharge timing would have averted this unfortunate gap in critical transitional services.

## **GUIDELINE DEVELOPMENT**

Both these scenarios demonstrate that serious lapses can occur when hospital case managers and on-site liaisons are working together on discharge plans. Case managers at one metropolitan hospital acknowledged that it would be helpful to draw up a set of guidelines that would inform their practice with home care liaisons. A workgroup of five experienced case managers was formed to address this identified need. In a review of literature, they were unable to find any articles discussing the collaborative work of hospital case managers and home care liaisons. The hospital case

management workgroup set out to discuss and define their responsibilities when coordinating plans with home care liaisons. They gathered information, both written and verbal, from other members of their 26-person case management department. They also reviewed job descriptions for both hospital case managers and liaisons from three other metropolitan medical centers, two skilled nursing facilities, and five home care agencies. They held multiple meetings and discussions among themselves and with their liaisons to develop an initial set of guidelines for practice at their facility. On review of the initial drafts, all the participants agreed that guidelines would be very helpful and noted that their respective organizations did not have specific documents regarding collaborative work between hospital case managers and home care liaisons. Several case managers expressed that simply reviewing the guidelines had made them more mindful to clarify roles and responsibilities and to follow through more thoroughly on details of patients' discharge plans when working with liaisons.

Many issues were discussed as potentially influencing the complexity of care coordination when hospital case managers and on-site liaisons work together on discharge plans. For example, the backgrounds of home care liaisons vary by discipline, licensure, experience, educational preparation, and training for their roles. Similarly, case managers have different backgrounds, experience, expertise, and practice styles. In addition, case managers and liaisons were found to have conflicting expectations of one another's roles and responsibilities in the discharge planning process. Case managers expressed different levels of comfort and skill in delegating and/or sharing discharge planning tasks and communications with liaisons. Likewise, liaisons expressed inconsistent levels of comfort and/or practice with tasks involving team communications and actions. Case managers and liaisons agreed that problematic discharge planning coordination was often due to breakdowns in communication and incorrect assumptions about responsibilities and accountability.

Job descriptions for both liaisons and case managers also vary from one organization to another. For example, some liaisons are involved in marketing as well as patient care. This can create additional challenges for case managers who are required to offer patients objective choices regarding home care providers and are bound to protect confidential patient information. In addition, hospitals have differing expectations and requirements of liaisons in such areas as credentialing, orientation, access to patient units and records, and practice authority.

Several characteristics of role and function were identified as contributing to positive process and

outcomes for the patient, family, and health care team:

- Taking time to become familiar with one another's practices and backgrounds;
- Ensuring clear discussion and agreement regarding roles, responsibilities, and expectations in developing and implementing discharge plans for individual patients and consideration of organizational expectations and practice limitations in general;
- Providing time and forum for ongoing communication for information updates, identification of needs, and evaluation of progress toward goals;
- Recognizing that responsibility for certain aspects of the discharge planning process rests with either the case manager or the liaison; however, responsibility for other aspects of the process overlap and may be shared (see Table 1). Often, sharing certain responsibilities can contribute to a more comprehensive and coordinated plan.

Of note, the workgroup observed that the area of shared responsibility can potentially present the most pitfalls for discharge plans if clear communication relative to responsibilities does not occur. They agree that the case manager, in partnership with the multidisciplinary team, is ultimately accountable for the effectiveness and outcomes of the discharge plan.

The guidelines were written to highlight the roles and responsibilities of the case manager when working with liaisons. This focus came from a consensus that case managers are not directly responsible for the practices of home care liaisons. However, they are accountable for the ultimate completion and success of special discharge arrangements. At the same time, many liaisons are licensed professionals with standards of practice and unique expertise that are essential for effective discharge planning and interventions. They have roles and responsibilities for their agencies to ensure that the home care plan will be successful for their patients and home care colleagues. The workgroup agreed that the guidelines could be enhanced by adding content related to practice expectations for the home care liaisons. This would require developing a consensus with multiple home care agencies for these aspects of liaison practice. This was deemed to be beyond the scope of this workgroup's current project objectives.

The attached guidelines (Appendix A) are not intended to be inclusive of all possible aspects of case manager—liaison collaboration. Rather, they are meant to inform practice and increase awareness of aspects of collaborative process that require special attention and communication. The final version of the guidelines was accepted after multiple revisions, peer review by several of the hospital case managers and home care liaisons, and secondary review and editing by the director of the department.

## DISCUSSION

Anderson and Helms (1998) noted that “continuity of patient care involves a series of coordinating linkages across time, settings, providers, and consumers of health care. Communication is a core component of coordinating patient care. Increased and improved inter-organizational communication is needed when patients are discharged to...home health agencies” (p. 225). Without this, when a patient transitions from hospital to home, many critical details may be lost and many well-intended preparations may fail in fulfilling their objectives (Anderson & Tredway, 1999; Billings & Kowalski, 2008).

At the hospital where these guidelines were developed, case managers and home care liaisons are seen as members of the discharge planning team. They both participate actively in communication, planning, and actions; have input into the discharge planning conversation; and receive input from the other members of the discharge planning team. This team includes the multidisciplinary hospital care team, the patient and family, and other community providers and agencies that will be involved directly or indirectly in the home care plan. Each is responsible for his/her practice and for completion of essential activities for the discharge plan. The actions of one have the potential to inform and influence the actions of the other. All have accountability to the ultimate success of the transition to home care services. The contributions enhance the effectiveness of the discharge planning process and ultimate care and services to the patient and family. In short, they are partners in many aspects of discharge planning and coordination. Thus, the guideline workgroup agreed that both case managers and home care liaisons are well-advised to take the time to get to know each other's backgrounds and practice styles. It is of paramount importance that they communicate clearly and frequently when working together on individual discharge plans. In doing so, they can avoid pitfalls that can sabotage the effectiveness of care planning and leave patients and families with unexpected problems at times of increased stress and diminished endurance.

Going forward, the workgroup members are creating a formal teaching/training program for new liaisons at their facility that will include presentation of the guidelines and discussion of roles, responsibilities, and communication. They also have proposed having regular meetings with liaisons to discuss case scenarios and trends and update each other on any organizational changes that could impact their mutual practice. Finally, they plan to develop a way to measure the effectiveness of the guidelines in informing the practice of their case managers and will continue to revise the guidelines, if needed.

**TABLE 1****Examples of Individual and Overlapping Responsibilities of Case Managers and Liaisons in Discharge Planning**

	<b>Case manager</b>	<b>Overlapping</b>	<b>Liaison</b>
<b>Assessment</b>	<p>Assess appropriateness of home care plan and determine needs.</p> <p>Identify options for home care agencies on the basis of location and insurance contracts.</p> <p>Ensure patient/family agreement and ability to comply with plan.</p> <p>Initiate referrals on the basis of patient and family choice.</p>	<p>Verify funding source(s) for home care needs.</p> <p>Assess barriers for discharge, competing demands, and teaching needs.</p> <p>Work with health care team to develop an appropriate home care plan.</p>	<p>Verify and communicate insurance coverage and out-of-pocket responsibilities.</p> <p>Determine whether home care agency can meet patient/family needs.</p> <p>Identify possible options for plans, for example, pump choices for home intravenous therapy.</p>
<b>Planning</b>	<p>Clearly communicate expectations and needs to care team, liaison, patient, and family.</p> <p>Monitor and evaluate readiness for discharge.</p> <p>Modify overall plan on the basis of new information and needs.</p> <p>Communicate plan to patient's insurer as necessary.</p>	<p>Follow clinical progress.</p> <p>Collaborate with care team regarding what is needed to ensure coordinated plan.</p> <p>Arrange for in-hospital training, regarding clinical needs and supplies/equipment.</p>	<p>Provide equipment and skills teaching to patient and family as appropriate.</p> <p>Communicate individualized needs and plan to agency.</p> <p>Facilitate timely organization of home care services and supply deliveries.</p>
<b>Facilitation</b>	<p>Coach team regarding preparation of patient care referrals, scripts, letters of medical necessity, and so forth.</p> <p>Ensure regular updates to all home care providers and health care team.</p> <p>Ensure that team has accurate contact information for verbal reports and written referrals.</p>	<p>Coordinate first visit at home with care team, patient, and family.</p> <p>Verify that home care agencies have all necessary orders, scripts, and authorizations for services.</p> <p>Facilitate timely and coordinated discharge.</p>	<p>Ensure that home care branches have current information and contact numbers.</p> <p>Ensure that patients and families know agency resources and contact numbers for support and concerns.</p>
<b>Advocacy</b>	<p>Ensure prior authorization work is completed in timely fashion.</p> <p>Initiate referrals for additional resources and support services, for example, community case management.</p>	<p>Ensure that patient and family feel prepared for discharge.</p> <p>Evaluate effectiveness of transition to home care.</p> <p>Resolve problems.</p>	<p>Ensure that other home care agencies are prepared to work with their equipment/supplies.</p> <p>Identify and resolve potential variations in practice between hospital and home.</p> <p>Ensure all paperwork and orders are received by agency.</p>

*Clear and concise communication is essential in ensuring safe and well-coordinated discharges.*

## LIMITATIONS

It is important to acknowledge that the background and guidelines presented in this article can serve only as a beginning framework for discussion of the collaborative practice between hospital case managers and on-site home care liaisons. The main participants in this project were hospital case managers from one large northeastern metropolitan hospital. These participants solicited input from several other hospital case managers from different acute care settings in their geographic area. They also asked several on-site liaisons and case managers to review various drafts of the collaborative guidelines for content validity. All provided feedback that the guidelines were an important step in practice improvement. The guidelines have not been formally evaluated, nor are they intended to be all inclusive as currently written. The authors acknowledge that many more complex issues need to be considered related to the collaborative practice between hospital case managers and on-site liaisons. Furthermore, the authors have not included any discussion of hospital case managers' work with community provider liaisons that do not have a regular on-site presence in the acute care setting. There are undoubtedly commonalities in acute case managers' work with both on-site and off-site liaisons. However, the authors posit that unique challenges influence effective coordination of care when a case manager is working remotely with a community provider rather than directly with an on-site liaison.

The authors acknowledge that different hospitals have their own rules, regulatory requirements, and standards for working with home care liaisons. This clearly could influence the ability to generalize the content in this article. For example, many hospitals may restrict the practice of home care providers within the acute care setting in terms of chart review, meetings with patients and their families, and access to the health care team. Likewise, home care providers may have varying job descriptions, protocols, and standards that can influence the extent of their involvement and authority with patients, families, and care teams in the hospital setting.

This underscores the critical importance of communication and cross-checks when hospital case managers and home care liaisons are working together on

behalf of patients and their families in transition from hospital to home care.

## SUMMARY

Collaboration between hospital case managers and on-site home care liaisons is a dynamic process. The case manager and liaison have discrete responsibilities; however, their roles often do overlap. The experienced hospital case manager must remember that liaisons are not hospital employees and their agencies have varied job descriptions and expectations. Clear and concise communication is essential in ensuring safe and well-coordinated discharges. Likewise, follow-up communication is needed to ensure that key components of the discharge plan have been completed. The case manager needs to anticipate and continually evaluate care needs, patient/family abilities, and liaison expertise in any given clinical situation. The case manager must also clearly state his or her assessment of patient needs and expectations from the liaison. Input from the home care liaison invariably is quite valuable throughout the process. Case managers and on-site liaisons are advised to develop plans with clear delineation of roles and responsibilities. The case manager must adjust the plans on the basis of new needs and assessments of the effectiveness of existing plans. As the one who is ultimately in charge of coordinating special discharge arrangements, the case manager should facilitate ongoing communication with the care team, patient, family, and liaisons. Only through clear expectations, collaboration, and communication can hospital case managers and on-site liaisons achieve excellent outcomes for patients, families, and the health care team.

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## APPENDIX A

### Case Management Guidelines for Working With Community Provider Liaisons

#### Standard

Case managers frequently work with on-site community provider liaisons when coordinating discharge plans for patients and families. The ultimate responsibility for ensuring safe and well-coordinated plans lies with the multidisciplinary team. The community provider liaison plays a vital role in communications, needs assessment, patient/family education, problem solving, and discharge planning interventions. Effective communication and collaboration are essential for ensuring continuity of care.

#### Purpose

To outline case manager responsibilities when coordinating discharge plans with liaisons.

#### Guidelines

1. The medical team determines whether a patient is stable for discharge and communicates any after-care needs to the case manager.
2. It is the responsibility of the case manager to determine whether safe, timely, and appropriate arrangements can be made for discharge and to communicate with the medical team regarding specific discharge planning needs.
3. Case managers refer to existing department resource information and home care resource directories for identification of community health care providers.
4. Case managers meet with the patient/family before initiating a referral to any home care provider to gain consent, offer choice, and provide anticipatory guidance regarding any home services. Likewise, the case manager meets with readmitted patients/families to ensure their agreement with rereferrals to previous community health providers.
5. Case managers make best efforts to ensure that the patient/family is aware of any preferred provider conditions before finalizing a referral.
6. Case managers notify liaisons when their companies' active patients are readmitted to the hospital. They also identify any problems/concerns with previous community health provider's services that need to be addressed and redirect the family accordingly.
7. Case managers must establish a plan with the community provider liaison for communications and follow-up throughout the discharge planning process.
8. Case managers ensure that the liaisons have access to all appropriate clinical and financial documentation.
9. Case managers facilitate communications among liaisons, the medical team, and the patient/family as necessary.
10. Case managers facilitate completion of documents needed to ensure continuity of care and funding approvals. This paperwork includes prescriptions, letters of medical necessity, and referral forms.
11. Case managers keep the liaisons up to date on any changes in the patient's status and/or care that impact discharge planning.
12. Case managers and liaisons collaborate to
  - a. Ensure insurance verification and/or authorization by payer,
  - b. Review local branch resources for problem solving and patient/family support, and
  - c. Identify any home care variations in community health providers' protocols from those followed by Children's Hospital Boston.
13. Case managers ensure that the community provider liaison meets with patients and families as appropriate to discuss coordination of community health provider's services and/or provide teaching.
14. Case managers may request that liaisons assist with
  - a. Setting up teaching times with families and providing patient/caregiver education for home infusion therapy and technology;
  - b. Ensuring communications and collaboration with all involved agencies, for example, setting up teaching sessions for home care providers regarding home care equipment;
  - c. Verifying that home care clinicians are scheduled to support patients/families with high-technological transitions post discharge;
  - d. Coordinating home delivery times and equipment setups;
  - e. When necessary, arranging for initiation of infusions or other therapies before discharge to ensure continuity of patient care;
  - f. Communicating patient and discharge information to their intake departments as well as ensuring that all relative paperwork is obtained and received by their intake departments;
  - g. Notifying case managers when they are aware of any patient readmissions and/or problems with previous community health provider's services; and
  - h. Evaluating the effectiveness of discharge plans and collaborative work and identifying opportunities for improvement.
15. The case manager ensures that patients/families have community health providers contact information and information on resources for questions or concerns post discharge.
16. The case manager ensures that the specifics of the final discharge plan are documented in the clinical record and discharge forms and that any problems have been addressed.



## Documentation

It is the responsibility of the case manager to document discharge-planning preparations. The community provider liaison may leave informal documentation in the patient charts to facilitate details of care coordination. The community provider liaison provides informational documentation regarding the discharge plan in the patient paper or electronic medical record.

**Margaret M. Kelly, BSN, RN**, is a hospital case manager at Children's Hospital Boston and Saint Elizabeth's Medical Center in Boston. She has nearly 20 years of nursing experience, including positions as a hospital-based home care liaison, a hospital case manager for adults and children, and an insurance case manager.

**Erika D. Penney, MSN, RN, CPNP, CCM**, is a hospital case manager at Children's Hospital Boston. She has 33 years of nursing experience, including more than 20 years in case management across the continuum. She has also practiced as a hospital-based home care liaison and home care provider. Her specialty is pediatrics.