DISCHARGE AND TRANSITION FROM HOSPITAL TO HOME FOR CHILDREN WITH MEDICAL COMPLEXITY

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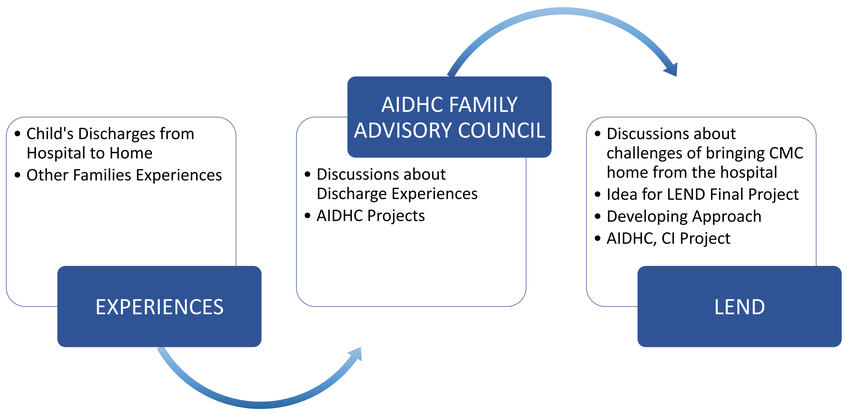
INTRODUCTION

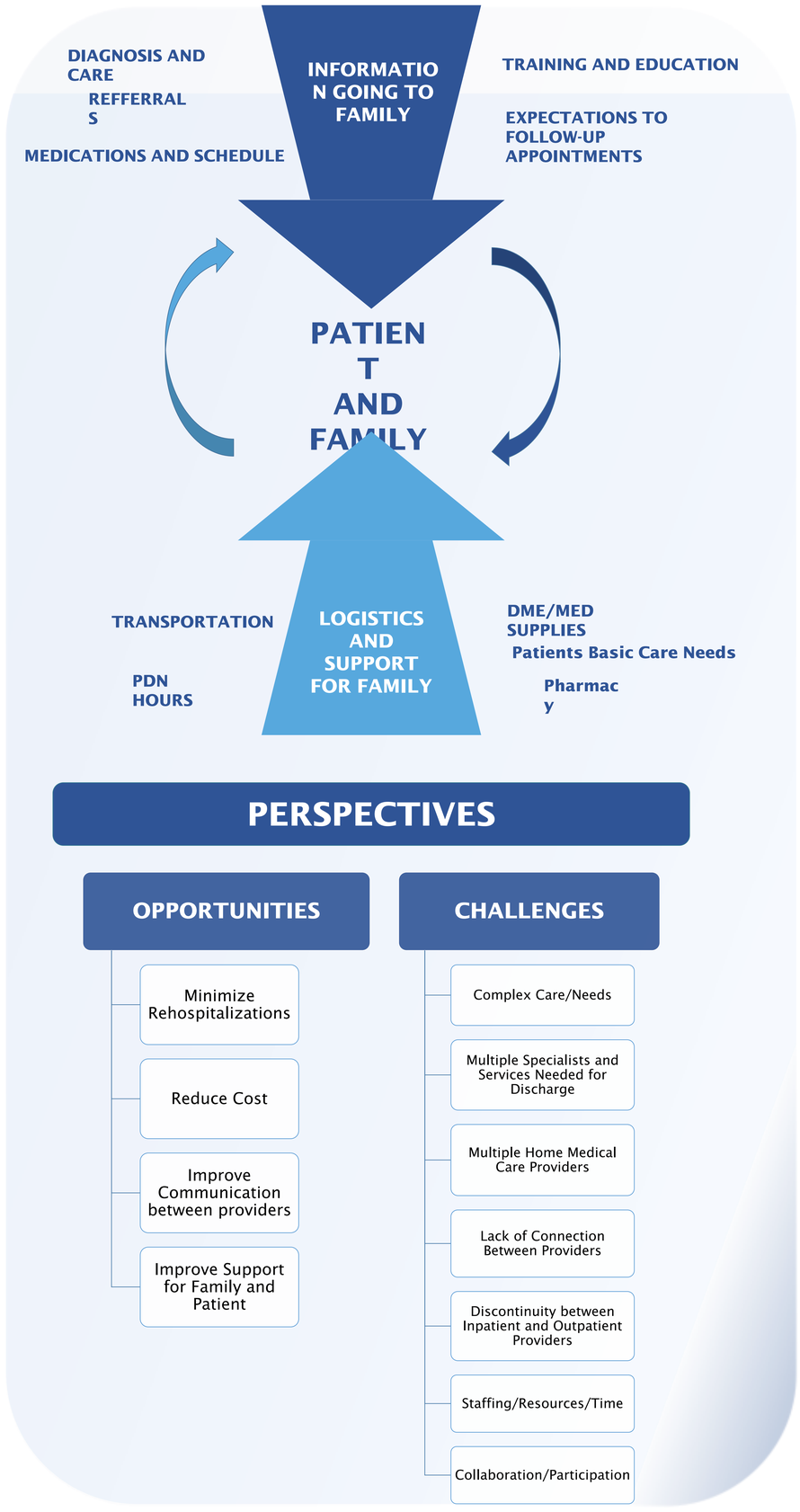
For a family of a Child with Medical Complexity (CMC) the process of discharge from hospital to home is very chaotic. It requires a more thorough approach, diverse care team and resources, it requires "comprehensive team coordination."[1] Successful transition is critical to the health and well-being of a child and family as a unit. And yet, "there is surprising lack of consistency in both the process and quality of discharge planning across the healthcare systems."[2] In this project we investigate challenges and possible tools to make this process easier, safer and less chaotic for the care team and the family/caregiver.

BACKGROUND AND TIMELINE



METHOD AND TOOLS

- Review Literature and Existing Discharge Models
- Collect Perspectives and Experiences of family caregivers and health care providers
- Observe Discharge Process
- Identify Gaps, Barriers, and Opportunities for Growth



PERSPECTIVES

OPPORTUNITIES

- Minimize Rehospitalizations
- Reduce Cost
- Improve Communication between providers
- Improve Support for Family and Patient

CHALLENGES

- Complex Care/Needs
- Multiple Specialists and Services Needed for Discharge
- Multiple Home Medical Care Providers
- Lack of Connection Between Providers
- Discontinuity between Inpatient and Outpatient Providers
- Staffing/Resources/Time
- Collaboration/Participation

STAKEHOLDERS

- FAMILIES AND CHILDREN WITH MEDICAL COMPLEXITIES
- MANAGED CARE ORGANIZATIONS
- DURABLE MEDICAL EQUIPMENT COMPANIES
- DMMA
- NEMOURS/Alfred I. Dupont Hospital for Children
- PRIVATE DUTY NURSING AGENCIES

SUGGESTIONS

- ❑ Multidisciplinary approach, including Family/Caregiver
- ❑ Create Checklists for Care Team and Family/Caregiver
- ❑ Create Care Folder for Family/Caregiver Before Discharge
- ❑ Assign Case Manager that would follow CMC

NEXT STEPS

- CREATE DISCHARGE STRATEGY
- CREATE TRAINING FOR STAFF INVOLVED IN DISCHARGE PLANNING
- CREATE TOOLS TO ENGAGE FAMILY/CAREGIVERS IN DICHARGE AND CARE PLANNING

References & Acknowledgements:

1. Roberts, S., Crigler, J., *Working with Socially and Medically Complex Patients: When Care Transitions are Circular, Overlapping, and Continual Rather Than Linear and Finite* . Vol.37 No. 4 July/August 2015
2. www.caregiver.org/hospital-discharge-planning-guide-families-and-caregivers
3. IDEAL *Discharge Planning,* www.ahrq.gov

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