

Q&A: Improving Discharge Care for Children with Special Health Care Needs through a Nurse-led Learning Collaborative

Below are responses to questions the panel was unable to answer during the webinar.

Respondents

- **Jennifer Baird, PhD, MPH, MSW, RN, CPN**, Principal Investigator, CANDLE Collaborative and Director, Institute for Nursing and Interprofessional Research at Children's Hospital Los Angeles
- **Kevin Blaine, MAEd**, Director, CANDLE Collaborative and Senior Research Associate, Institute for Nursing and Interprofessional Research at Children's Hospital Los Angeles
- **Melissa Gustafson, MSN, RN, CPNP**, Pediatric Nurse Practitioner, Lucile Packard Children's Hospital at Stanford
- **Angie Marin, MSN, RN-C**, Nursing Manager, Pediatrics, UC Davis Children's Hospital
- **Sarah Wilkerson, MSN, RN, CPNP**, Pediatric Nurse Practitioner, Monroe Carrell Jr. Children's Hospital at Vanderbilt University

Q&A

Discharge Huddle Management:

What time is the discharge huddle performed? How did stakeholders decide on the time?

Angie: Discharge huddles are held daily from Monday through Friday at 11:30 am. The time was chosen because it is directly before a noon meeting that medical teams need to attend and after rounds have been completed.

How did you determine which patients needed to be part of a more elaborate discharge planning?

Angie: All patients receive the discharge huddle regardless of their complexity, length of stay, and acuity. Some patients may need a more elaborate discharge plan because of their complex needs, usage of services, or social circumstances. In this case, the nurse that has been working with the family will ask for this additional planning to be set up. A nurse may also set up a weekly meeting to address discharge goals and needs when necessary.

Do any of the hospitals in the collaborative utilize a nurse navigator or discharge planner, in addition to a case manager? If so, what was each person's role, and how was the discharge process enhanced?

Children's Hospital of Orange County (CHOC) is a participant in CANDLE but did not present during the webinar. At CHOC Children's there is a Discharge Nurse Navigator (DNN) team of 2.5 Full-time equivalent (FTE) Registered Nurses (RN). The RNs work once per day for 12 hours. There is a DNN working 7 days a week. They are involved with discharge education, identifying primary and secondary (at minimum) care givers, helping to align parent and patient goals with medical discharge goals, and utilizing teach back in all aspects of care. Bedside RNs are responsible for regular nursing education and the discharge process. The DNNs are an extra layer of support for complex patients and/or social situations. They currently round on Medical, Neuroscience, Multispecialty, and Surgical Acute Care floors with patients who are identified at moderate or high risk for readmission have requests from medical/nursing teams, and/or are patients on California Children's Services (CCS) hold.

Can you discuss what the teams do for weekend discharges?

Angie: We have a case manager on the weekends. However, the unit discharge planner sets up the discharge for any weekend discharges (including supplies, placement and durables). These are arranged on Thursday or Friday morning.

Home Care typically does not do first visits on the weekend so we plan to have children with home care nursing discharged on Thursdays so that they can have a Friday visit or Sunday with a Monday visit arranged.

Training and Education:

How do the different hospitals communicate with the patient's primary care provider to ensure follow-up and share changes in status or medications?

CANDLE Member from CHOC: A discharge summary is automatically faxed to the pediatrician at the time of discharge and Hospitalists/Intensivists will use a HIPAA secure texting platform for communication between care team members for more involved patients.

Where can we find the discharge standards?

The discharge standards can be found in JAMA Pediatrics (doi: [10.1001/jamapediatrics.2014.891](https://doi.org/10.1001/jamapediatrics.2014.891))

Is it appropriate to ask a medical institution if they employ the use of a Discharge Pharmacist?

Sarah: Yes, most definitely. Sometimes institutions utilize pharmacy technicians who may be more accessible than an actual pharmacist. Also, if your child is being cared for at a teaching institution, a pharmacy resident may be available. Even if this person is not formally called a "discharge pharmacist," it is appropriate to request that your child's medications are reviewed before discharge with a member of the pharmacy team.

How can discharge planning incorporate ensuring complex kids have Medicaid eligibility and home nursing care upon discharge, if eligible?

Sarah: We typically utilize a social worker for the question of Medicaid. Eligibility will differ state to state. In Tennessee, it is income-based only, and your child must qualify for Supplemental Security Income before being eligible. In many states, eligibility is based on diagnosis. Typically, at most institutions, a social work screening tool is part of the initial admission intake and this would be the time for families to ask for a social worker to answer any questions about eligibility. Home nursing care is something that is typically addressed by a case manager. Most inpatient units have a case manager assigned who helps with durable medical equipment (DME) needs and applying for home nursing or requesting an increase in nursing hours. This is usually something that is on the hospital staff's radar if you have a medically complex child, but if you have specific questions, don't hesitate to ask!

Involvement with CANDLE:

How can home care providers get involved in the CANDLE collaborative work?

This is a great question. Since members of the community assume the roles and responsibilities post-discharge, it absolutely makes sense to involve key stakeholders representing these types of organizations in the CANDLE Collaborative. We think the best fit would be inclusion as participating members of the CANDLE advisory committee. We'll consider this moving forward into Year 2 of our grant-funded work.

Post Discharge:

Is anything being done at discharge to help connect families with community organizations, therapists, or other supports?

- Social work services are available to all patients. When a nurse completes an assessment, there are items that will lead to an automatic flag for a social work consultation. Complex patients have an outpatient case manager who follows them throughout the ambulatory clinic(s).
- Trauma patients all receive a Psychology consultation and are connected to community resources as appropriate.
- Case management is involved with each inpatient admission and completes rounds on each service.

Is there a follow-up call with parents after discharge to ensure all is going well and to ask if other services are needed?

Sarah: At Vanderbilt, as part of our complex care program, we have our nurses routinely do discharge follow-up calls within 72 hours of discharge for all patients from our program who have been admitted to the hospital. This is something we have been doing for several years and it results in great patient and parent satisfaction. At the very least, if your institution does not routinely do discharge follow-up calls, you should ensure that the phone numbers for the specific providers that the care givers may need to contact about issues that arise post-discharge are listed on your discharge paperwork. Unfortunately, the pediatrician often ends up fielding many of these calls and they may not have the resources or pertinent information to fully close the loop or help solve an issue with the family.

Environmental Factors:

Have you run into any experiences associated with discharge of children with complex needs back to communities impacted by wildfires?

Multiple CANDLE member hospitals have been in the position of needing to assist families with finding housing for evacuated patients. Some have housed families at their local Ronald McDonald House or Rotary House, but it really depends on each individual family and their unique needs. Other impacts have included dialysis centers burnt down and lack of home nursing staff trained for care of central lines.

How has the COVID-19 pandemic impacted preparing families for discharge?

The pandemic has absolutely impacted preparing families for discharge. Challenges include hospital visitation restrictions – either for family members or durable medical equipment (DME) suppliers and trainers. Many families may not want to go back to a subacute care unit because they won't allow visitations with the child. As for DME companies, they don't want to come into the hospital, and finding a quiet place for families to meet them and receive training can be a challenge. Additionally, at least in the beginning of the pandemic, some foster care providers and group homes wanted to confirm that every child entering their care first tested negative for COVID, including those who had no known exposure. As such, new policies were put in place allowing for written waiver of those requirements.