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The Role of the Home Care Clinical Liaison in Supporting Safe Transitions of Care for Interventional Radiology Outpatients

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A B S T R A C T

Interventional radiology (IR) patients who historically convalesced in an inpatient acute care setting are now being discharged home directly after the procedure. The shift toward offering care on an outpatient basis entails that patients with acute and complex care needs are now being cared for in the community. This necessitates the safe transfer of patients to the appropriate postacute setting to facilitate a successful recovery. Clinical liaisons in conjunction with physicians, nursing, and other medical staff have a pivotal role in guiding this transition of care to enhance the recovery process and patient experience. The focus of this article will examine the clinical liaison in the postdischarge management of patients after IR procedures and the value that this role adds to patient safety and quality.

Introduction

The postacute health care continuum includes inpatient rehabilitation facility (IRF), long-term acute care (LTAC), skilled nursing facility (SNF), home care, and outpatient facilities. There are many types of agencies that can provide services within the patient's home environment, including certified home care, hospice, agencies on aging, homemaker services, and private duty nursing. Other companies may be used to deliver specialized services and products, such as medical equipment and supplies, pharmaceuticals, and drug infusion therapy. Home care-certified services can include skilled nursing, home health aide (HHA), rehabilitation including physical, occupational, and speech therapies, social work, and palliative care. In addition to the traditional services listed, some agencies are innovating by providing nurse practitioners as an adjunct service as well (Figure 1).

Reduction in length of stay (LOS) at the acute hospital level of care (LOC) necessitates sending patients to the appropriate setting to facilitate successful recovery. Factors in the current reimbursement structure support more efficient transitions to the postacute setting.

Considerable effort is currently underway to reduce LOS and readmissions. Through provision of home care services, patients are able to avoid the costs and risks of hospitalization and rehospitalization, returning to their home environment while receiving expert nursing care and rehabilitative services (Meadows, Fraser, Camus, & Henderson, 2014). Clinical liaisons work in conjunction with nursing and medical staff, providing a process to provide quality care and patient experience while patients transition back into the community. The focus of this article is to discuss the role of the clinical liaison with the use of home care for patients' status after interventional radiology (IR) procedures (e.g., PleurX catheter placement [Becton, Dickinson and Company, Franklin Lakes, NJ], nephrostomy tube placement, vascular access devices or gastrostomy tube placement) and the value that this role group provides to patient safety and quality.

Background: Role of the clinical liaison

There are many definitions for the term liaison across multiple information sources. The word liaison is defined as communication or cooperation that facilitates a close working relationship between people or organizations or a person who establishes and maintains communication for mutual understanding and cooperation (Dictionary by Merriam-Webster, 2017). This definition is consistent with the role of the Partners HealthCare at home clinical liaison. In this setting, the role requires that the clinical liaison carry a license in one of the following practice areas: registered nurse, speech-language pathology (SLP), physical therapy (PT), occupational therapy (OT), and licensed clinical social work (LCSW).

As a representative of the postacute care setting, the clinical liaison's primary role is to manage the smooth transition of care from acute care services to postacute care services. This is accomplished by establishing a collaborative relationship with the case manager, clinical care team, patient, and family. The clinical liaison coordinates the referral process to the appropriate postacute care

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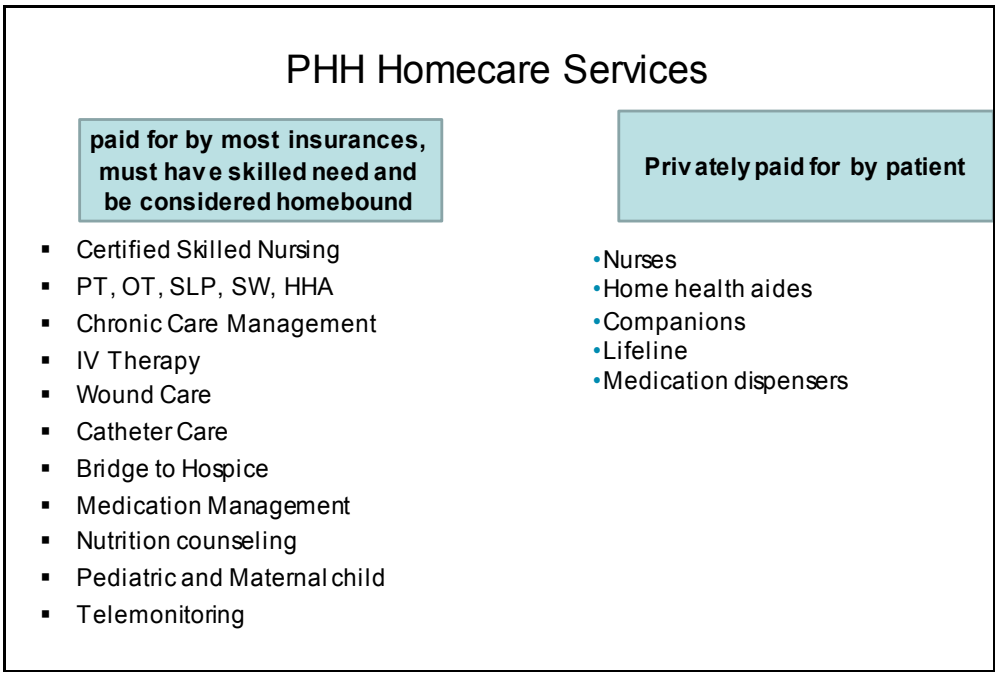

Figure 1. Example of certified and private home care service options. PHH, Partners HealthCare at home; PT, physical therapy; OT, occupational therapy; SLP, speech-language pathology; SW, social worker; HHA, home health aide; IV, intravenous.

setting after review of the clinical information, discussion with the case manager and providers, and a meeting with the patient and/or family. Through this collaborative process, the clinical liaison considers alternatives and options that would best meet the patient's needs by aiding in the determination of an appropriate discharge plan. Identification of additional resources or programs as well as barriers or obstacles to the plan (e.g., insurance restrictions) are also elements of the clinical liaison role.

Historically, the clinical liaison began as an inpatient role to help transition patients from an acute care hospital to an appropriate postacute facility such as an IRF, SNF, or LTAC hospital. The clinical liaison's role has since expanded to include the transition from all inpatient facilities (acute care hospitals, IRFs, SNFs, and LTACs) to home care as the postacute provider. Furthermore, with today's advances in health care, many procedures, surgeries, and treatments are increasingly moving to day surgery and outpatient arenas. The role of the clinical liaison has become instrumental to successful outcomes for IR patients who need home care services to achieve a safe recovery at home. With these compelling opportunities and related demands to reduce LOS and readmission rates at large institutions and health care systems, such as the Massachusetts General Hospital (flagship facility for Partners HealthCare System), a designated clinical liaison has been assigned to the IR department.

Education and collaboration in the IR setting

Collaboration among health care workers is imperative for a successful transition home to decrease readmission rate and increase success in the home environment. As many of the procedures performed in an IR outpatient setting have life-altering implications for patients, it is critical to have a member of the team in place whose sole focus is to create a plan that supports patients after discharge care. Identification of a patient in need of additional postdischarge nursing support is the catalyst for involving the clinical liaison in the patient care plan. Referrals and consults are initiated by phone or e-mail, wherein nurses provide the patient name, medical record number, services they are requesting, and the service address (Figure 2). Referrals are facilitated at any point along the procedure process (from the time of the preprocedure phone call through the time of postprocedure discharge). Once specific needs for professional care have been identified (e.g., dressing changes and port access, draining PleurX catheters [Becton, Dickinson and Company, Franklin Lakes, NJ] feeding tube management, nephrostomy tube care, pheresis line care, or intravenous [IV] medication administration), the referral to the clinical liaison is made, and the patient's treatment begins.

Meeting the patient and caregiver can allow for questions to be answered and expectations to be set before discharge, ensuring the success of the patient's transition and interactions with home care providers. The home care agency clinicians reinforce teaching in the home, provide medication reconciliation and psychosocial support, and evaluate the need for additional services, including PT, OT, SLP, LCSW, and HHA. This is crucial for patients who are recovering from sedation and analgesia at the time of initial postprocedure teaching.

Collaboration among clinical liaisons and radiology nursing staff is critical and has proven to be effective in identifying patients in need of additional support in the home care setting. Including a home care referral in the postacute care plan will confirm compliance of important inpatient teaching done after the procedure. Within the spectrum of home care services are professionals who have complex knowledge of service provision within the home environment as well as the nuances involved with reimbursement.

Radiology nurses are often recruited from high-acuity inpatient and interventional settings, and the production pressure within this environment leaves little time for care coordination. Subsequently, educating nurses in all stages of employment is imperative to the success of the partnership. Clinical liaisons initiate and complete the home care referral process, which is a valuable resource for staff in IR departments. Nursing education can be achieved through participation/presentation at staff meetings, e-mail flyers, posting contact information within the department, and participation in new nurse orientation. Educating newly hired nurses exposes them first hand to the transitions of care to make it more of an automatic part of their postcare procedures.