EP6a – INTERPROFESSIONAL CARE

COORDINATING CARE FROM INPATIENT ACUTE REHABILITATION TO HOME HEALTHCARE SERVICES

Provide one example, with supporting evidence, of nurse's(s') participation in interprofessional collaborative practice to ensure coordination of care from an inpatient setting to an ambulatory care setting.

Care Coordination from Inpatient to Home Setting

Nurse case managers at NewYork-Presbyterian/Columbia University Irving Medical Center (NYP/Columbia) play key roles in interprofessional collaborative practice to ensure patients receive the comprehensive care they need. Critical components of delivering comprehensive care include successful coordination of care from an inpatient setting to an ambulatory care setting.

As a nurse care manager, Goldilock "Goldie" Tan, BSN, RN, CNN, clinical nurse, led interprofessional collaborative efforts to safely and successfully transition care of a 56-year-old female patient from an inpatient acute rehabilitation unit, Rehab (8GN-605710) [8GN] Unit, to home with healthcare services. On July 24, 2023, Caitlyn Ko, MD, resident, Rehabilitation Medicine, and Akin Beckley, MD, attending physician, Department of Rehabilitation and Regenerative Medicine, NYP/Columbia, evaluated and admitted the patient to 8GN following a complicated inpatient postoperative course involving acute hypoxic respiratory failure requiring reintubation, bilateral pleural effusions, right femoral deep vein thrombosis requiring inferior vena cava filter placement, and myopathy, and lung transplant. The patient stated that prior to admission she lived in New York, and was independent in activities of daily living with use of a scooter for community mobility. The provider requested referrals for home care to include physical therapy and occupational therapy. With regards to transitioning from inpatient rehabilitation to home health care services, the patient stated, "I feel ready." Ms. Tan reviewed Dr. Ko's documentation and discussed the patient's needs with the interprofessional team and the patient. EP6a.1—History and Physical

Following the referral orders, Ms. Tan met with the patient and the team on August 2, 2023. Ms. Tan verified the patient's wishes and noted her extensive hospitalization and complex case. Ms. Tan recognized that the patient, supported by her husband, would need coordinated plans for inpatient care and for the transition to a community setting. Ms. Tan submitted a revised home healthcare services referral through CarePort, an electronic referral management system, to seek home care services for the patient who planned to be discharged to Connecticut (CT). The referral included physical therapy (PT), occupational therapy (OT), and nursing services. EP6a.2—Home Health Services Referral

On August 4, 2023, Ms. Tan was notified by PT that the patient and her spouse were scheduled to receive family training on August 14, 2023, and August 15, 2023 in order to prepare her for discharge. On August 9, 2023, during an electronic communication exchange with the interprofessional team, Georgia Rowntree, Physical Therapist and Emily Barnable, Physical Therapist confirmed the appointment with the patient and husband for family training. EP6a.3—Case Mgr Note and EPIC Chat August 2023

On August 7, 2023, Ms. Tan noted that certified home health agencies (CHHA) in the CT area were declining acceptance of her after hospital plan of care due to insurance and or capacity issues. Ms. Tan sent updated clinical information to the insurance company via CarePort which she hoped would help increase her chance of acceptance for in-home care. However, on August 11, 2023, Ms. Tan met with the patient to let her know that the patient was approved for limited in-home PT services. Therefore, to ensure comprehensive care and transition of services, Ms. Tan provided the patient with a list of rehabilitation clinics in the area so she could seek outpatient care which her insurance supported. Ms. Tan advocated for the patient to comply with the discharge plan of care for outpatient physical therapy to help strengthen and improve her mobility. Ms. Tan validated the patient's preferences to return to previous level of functioning and emphasized her desire and motivation to follow through with the therapy needs as an outpatient. Ms. Tan also addressed the concerns and questions the patient had regarding discharge care and rehabilitation plans. EP6a.4—Case Mgr Discharge Note, Outpatient August 2023

On August 16, 2023, during interdisciplinary rounds (IDR), Ms. Tan and the interprofessional team mutually agreed with the patient that she was ready for discharge. Ms. Tan confirmed that physical therapy completed the training with the patient to ensure a safe discharge to home with in-home PT. Ms. Tan coordinated the services and transportation at discharge with the patient's husband. As a result of Ms. Tan's interprofessional coordination efforts, the patient was discharged and had a smooth transition from the inpatient acute rehabilitation setting to her home, where she

would receive home healthcare services and outpatient care. EP6a.5—Final Discharge Note

Caitlyn Ko, MD
Resident
Physical Medicine and Rehabilitation

H&P
Attested

Date of Service: 7/24/2023 3:31 AM

This note has been co-signed/attested; do not edit unless there is an error that will affect patient care. If edited, the attending will need to re-attest. Consider creating an Event note for additional documentation.

Attestation signed by Akin Beckley, MD at 7/24/2023 1:08 PM

I saw and evaluated the patient and agree with the resident's history, physical exam, assessment and plan of care.
56 y.o. F with complicated hospital course following bilateral lung transplant for interstitial pneumonia. Post-op course complicated by acute hypoxic respiratory failure requiring re-intubation, b/l pleural effusions, right femoral DVT s/p IVC filter placement, diarrhea and ICU myopathy. She has need for physical and occupational therapy and close medical monitoring s/p transplant.

REHAB ADMISSION NOTE

Name: [redacted]
DOB: [redacted]
MRN: [redacted]
Date: 7/24/23 at 3:31 AM

Discharging Service: Pulmonary Medicine
Admit Date: 7/24/2023
Attending Provider: Akin Beckley, MD
[redacted]
IRF Admitting Diagnosis: No Principal Problem: There is no principal problem currently on the Problem List. Please update the Problem List and refresh.

CC: "I feel ready"

Patient Report: Patient seen at bedside. States that prior to hospital admission she was completely independent with ADLs and ambulation. States that occasionally in the community she would use a scooter to get around long distances. Denies any abnormal chest pain or difficulty breathing. States that she typically gets sore after the therapy session. Also reports that she has been having nausea, vomiting, diarrhea as it was result of the mycophenolate medication. States that diarrhea has been slowing down, C diff negative, and nausea he was helped with Zofran. Patient reports she is still able to tolerate food. States that she lives at home with her husband and they have 3 steps to enter the mobile home. Also reports she is raising 4 grandchildren. States husband is coming on Friday 7/28 and bring her new shoes. States that since she found out she had DVT her lower extremities have been edematous however left is improved and right lower extremity still has lots of edema.

History of Present Illness:
[redacted] is a 56 year old female right-handed previously independent but had occasional assistance at home/in community female with hx of ILD who was admitted on 6/2/2023 for increased oxygen requirements s/p double lung transplant (s/p VV-ECMO) with postoperative course complicated by hypoxic respiratory failure requiring reintubation, DVTs requiring IVC filter placement , Afib RVR, Pericardial and pleural effusions.

History of Present Illness:
[redacted] is a 56 year old female right-handed previously independent but had occasional assistance at home/in community female with hx of ILD who was admitted on 6/2/2023 for increased oxygen requirements s/p double lung transplant (s/p VV-ECMO) with postoperative course complicated by hypoxic respiratory failure requiring reintubation, DVTs requiring IVC filter placement , Afib RVR, Pericardial and pleural effusions.

Prior Level of Function: Previously independent in ADLs and home mobility without use of assistive devices, has a a scooter/wheelchair for community mobility.

Social History:
- Marital Status: married
- Living Situation: double wide trailer in upstate NY
- Stairs to enter home: 4
- ETOH/Tobacco/Recreational Substances: denies currently, hx of PSUD

Review of Systems (ROS):
All other systems reviewed and are negative as of 07/24/23, except as noted below.
Endorses nausea, vomiting, diarrhea, lower extremity edema, skin breakdown in the groin
Denies bowel or bladder incontinence, chest pain, change in vision, change in hearing, difficulty eating, dyspnea, numbness or tingling

HISTORY

Past Medical History:

Past Medical History:

Diagnosis	Date
• Anorexia nervosa, unspecified	
• ILD (interstitial lung disease)	
• IPF (idiopathic pulmonary fibrosis)	
• NSIP (nonspecific interstitial pneumonia)	
• Pneumothorax, unspecified *left*	2002
• Weight loss	

Past Surgical History:

Past Surgical History:

Procedure	Laterality	Date
• BILATERAL SACROPLASTY WITH MECHANICAL DEVICE		
• LAP,CHOLECYSTECTOMY		2023
• LAP,DIAGNOSTIC ABDOMEN		
• VATS (VIDEO-ASSISTED	Right	04/18/2022

[redacted] ☆

Gender: Female [redacted] Admission Date: 07/24/2023 Discharge Date: 08/16/2023 Patient Discharged: Yes LOS: 23d 14h Location: MIL 8 GARDEN NORTH / [redacted]

Referral Type: Home Health Care Services - [redacted]

- Face Sheet
- Patient History
- Patient
- Admission
- Assessment / Needs
- Forms and Attachments
- CM Assessments
- Documentation
- Discharge Planning
- Printable Documents

Referrals

- [redacted]
  - Summary
  - Communications
  - Printable Referral Data
  - Patient Choice Letter
  - Post-Acute Auth

Referral Type:	Home Health Care Services	**Number of Recipients:**	12
Status:	Sent / Not Placed / Open	**Deferred:**	
Created:	8/1/2023 6:09 PM (ET)	**Created By:**	Denisse Hernandez
First Sent:	8/1/2023 6:18 PM (ET)	**First Sent By:**	Denisse Hernandez
Most Recent Revision:	8/2/2023 2:07 PM (ET)		
Last Sent:	8/2/2023 2:07 PM (ET)	**Last Sent By:**	Goldilock Tan
Placed:		**Placed By:**	
Placed With:			
Closed:		**Closed By:**	
First Yes Response Received On:		**First Yes Response Recipient:**	
Referral Comment:	Hello, patient will need home PT/OT/RN and she is staying at [redacted] post DC. Clinicals uploaded.		

Recipient	Location	First Sent On	Respond By	Date and Time Provider Can Take Patient	First Response Received	Last Response Received	Last Response	
Atrinity Home Health, LLC (Formerly Synergy Home Health, LLC) Phone: (203) 699-9104 *** COVID-19: NOT able to accept COVID-19 positive patients**	8 Research Parkway, Suite 2 Wallingford, CT 06492	8/1/2023 6:18 PM (ET)	8/2/2023 8:30 AM (ET)	-	8/2/2023 8:43 AM (ET)	8/2/2023 8:43 AM (ET)	**Response:** No, unable to accept patient **Reason:** Other (see comments) **Comments:** Unable to accept at this time	Waiting for you
CenterWell Home Health - Old Saybrook Phone: (800) 280-8202 *** COVID-19: Willing/Equipped to accept COVID-19 positive patients,* High-Risk Isolation Patients: Willing/Equipped to accept High-Risk Isolation Patients**	210 Main Street, Ste 1A and 2 Old Saybrook, CT 06475	8/1/2023 6:18 PM (ET)	8/2/2023 8:30 AM (ET)	-	8/1/2023 6:56 PM (ET)	8/1/2023 6:56 PM (ET)	**Response:** No, unable to accept patient **Reason:** Other (see comments) **Comments:** Thank you for the referral, but we are at capacity.	Waiting for you
Enhabit Home Health - RCK (Formerly Encompass Health) Phone: (860) 529-5400 **NA** *** COVID-19: Positive patients under care,* COVID-19: Willing/Equipped to accept COVID-19 positive patients,* High-Risk Isolation Patients: Willing/Equipped to accept High-Risk Isolation Patients**	2080 Silas Deane Highway 2nd Floor Rocky Hill, CT 06067	8/1/2023 6:18 PM (ET)	8/2/2023 8:30 AM (ET)	-	8/2/2023 10:34 AM (ET)	8/2/2023 10:34 AM (ET)	**Response:** No, unable to accept patient **Reason:** Out of Service Area	Waiting for you
Hartford Healthcare at Home – Home Health and Hospice Services Phone: (860) 862-1551 *** COVID-19: Positive patients under care,* COVID-19: Willing/Equipped to accept COVID-19 positive patients,* High-Risk Isolation Patients: Willing/Equipped to accept High-Risk Isolation Patients**	1290 Silas Deane Highway Ste. 4B Wethersfield, CT 06109	8/1/2023 6:18 PM (ET)	8/2/2023 2:36 PM (ET)	-	8/2/2023 8:33 AM (ET)	8/2/2023 3:27 PM (ET)	**Response:** No, unable to accept patient **Reason:** Out of Network **Comments:** I'm sorry we are unable to accept patient insurance	Waiting for you

Goldilock Tan
Case Manager
Specialty: Case Management

Progress Notes
Signed

Date of Service: 8/4/2023 12:40 PM

SW/CM Progress / Reassessment

Progress Note: CM got notified by Georgia, PT that pt. already set up a schedule for pt's spouse to attend family training on August 15 and 16.

Interpreter Services:

Modality:

Conversation with Roberta A Lopez, OT; Emma Harmon, OT; Lola Soloveychik, PT; Carly Goldberg, OT; Danielle Crispin, PT; Emily Barnable,...

[redacted], 56y F
Shazia Janmuhammad, MD

Hello team, Pt. confirmed that family training with the husband will be in 8/14 and 15. Thanks.
Aug 9, 12:37 PM

Georgia Rowntree, PT was added by **Emily Barnable, PT**.
Aug 9, 12:47 PM

Emily Barnable, PT

Great thank you! will the husband be present all day on both the 14/15th so we can schedule appropriately
Aug 9, 12:49 PM

yes he is
Aug 9, 1:07 PM

**Secure chat message via EMR, EPIC, that reflects communication among PT, OT, and other interprofessional members who are associated with the case.

Goldilock Tan
Case Manager
Specialty: Case Management

Progress Notes
Signed

Date of Service: 8/7/2023 6:59 PM

SW/CM Progress / Reassessment

Progress Note: CM sent updated clinicals to the insurance company via payor communication tab.

Interpreter Services:

Modality:

Goldilock Tan
Case Manager
Specialty: Case Management

Progress Notes
Signed

Date of Service: 8/11/2023 10:01 AM

SW/CM Progress / Reassessment

Progress Note: CM spoke with pt. and discussed discharge planning and the availability of Outpatient rehabilitation services. I gave a list of rehabilitation clinics around local area where she's at as per her request. I emphasized the benefits of these services on helping her regain strength improve mobility, and enhance her overall functioning. CM also addressed any concerns or questions the patient had regarding discharge care and rehabilitation.

Goldilock Tan
Case Manager
Specialty: Case Management

SW/CC Disposition Note
Signed

Date of Service: 8/16/2023 10:01 AM

Rehab SW/CM Discharge Plan/Final Note

Discharge Note: Patient discussed in IDR's and as per team, patient is medically stable for discharge. Patient will be discharged home. As per PT recommendations, Pt. will be going home with home PT. CHHA is not accepting pt's insurance in CT. Referral for rehab to CUIMC was sent as per Dr. Ton. Pt. in agreement. Her husband will pick her up today for discharge.