



Hospital to Home: A Guide for Transition Planners

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Purpose

This manual has been developed to assure that Local Planning and Coordinating Councils (LPCC), in partnership with hospital personnel, have accurate and practical information to design, implement and evaluate their own transition procedures. These procedures will allow them to work together to:

- address each family's needs during the child's hospitalization.
- provide a smooth transition when the family brings the child home.
- utilize the hospital and early intervention providers' expertise to meet an array of individual needs.
- coordinate child assessments and other hospital and early intervention activities to eliminate duplication.
- assist with financial issues



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by:

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First Steps: 1-800-441-7837

Indiana Department of Health: 1-433-0746

Indiana Educational Resource Center: 1-800-833-2198

Interagency Planning

Benefits of Transition Planning

LPCC planning for transitions from hospital to early intervention services provides a systematic procedure which guides hospital and community service providers as they plan transitions with individual families.

Families

Smooth transition
Increased support
No interruptions in service
Financial Planning
Combined Enrollment Form
Links to local resources
Variety of information

Hospitals/Physicians/First Steps Providers

Uniform transition practices
Increased efficiency
Decreased duplication
Written procedures to guide practice
Access to multiple screens
Consistency in care from hospital to home
Families as active partners

Steps to Initiate a Community Transition Planning Team

First, LPCCs should assess the need to revise, update or develop a community transition plan. Ask families of children recently hospitalized how they feel about the transition home from the hospital. How were their family needs met during the child's hospital stay? After they left the hospital, were families able to access the early intervention services available to themselves and the child? What suggestions do they have to improve the transition?

Second, ask hospitals and county System Point of Entry (SPOE) offices if there is an established line of communication between hospital and early intervention services. Do providers know whom to contact to make referrals or to obtain information? Do they know when a referral is appropriate? Is hospital staff aware of eligibility criteria for First Steps early intervention services to make wise decisions about referrals? How do hospitals and the First Steps Early Intervention system support families during the child's hospitalization? What suggestions do providers have to improve transitions?

If the assessment supports a need for transition planning, then gather a team of family members and service providers who are dedicated to improving the transition. Service providers should represent all agencies that are providing services to families and infants. Team members need support to have the necessary time and authority to make procedural decisions.

Partners for Hospital to Home - Community Transition Planning Teams

- FAMILY MEMBERS (whose children have been in NICU or recently)
- HOSPITAL (administration, unit staff, social work department, financial counselors, discharge planners)
- HEALTH DEPARTMENT (Maternal and Infant Program, Healthy Start)
- FIRST STEPS SERVICES (System Point of Entry Intake Coordinator, Local Planning and Coordinating Council Representatives)
- OTHER KEY PEOPLE (important to families or instrumental in the community)

Hospital to Home Transition Guidelines

PURPOSE:

To provide families, hospital service providers and the First Steps Early Intervention system with a more uniform hospital-to-home transition plan for children eligible for First Steps Early Intervention services in Indiana.

TARGET POPULATION:

Children who have or are at-risk for developmental delays as outlined in the eligibility criteria for First Steps Early Intervention services and their families.

Planning for the interagency meeting:

- Hold transition planning team meetings at the hospital.
- Involve a parent whose child was a patient of a key physician.
- Make personal visits to key medical and agency staff.
- Involve both administrators and direct service providers.
- Allow involvement to be one-time or ongoing.
- Determine that all intra-agency systems are functioning.

Interagency meeting agenda items:

- Arrange to make presentations at Grand Rounds, staff in-services, subsection meetings and interagency meetings.
- Learn the basics of terminology used by various agency and hospital staff.
- Allow time for representatives from each agency and hospital to explain the services they provide.
- Chart each step of transition to visualize how a family proceeds from hospital into community services; determine if improvements are necessary; and then put it in writing.
- Use case reviews to evaluate a recent transition.
- Involve a member of the hospital forms committee--either as a team member or as a reviewer--to evaluate proposed forms.
- Start with medical and agency forms and procedures that are in place--review and adapt them to meet First Steps Services requirements. (Example: modify the hospital care plan to include the requirements of an interim Individualized Family Service Plan [IFSP].)
- Plan to complete an Individualized Family Service Plan (IFSP) or interim IFSP to meet family needs while the child is still hospitalized.
- Coordinate hospital social services with community-based services to provide for family needs during the child's hospitalization (information, transportation, child care for other children).
- Plan ahead with community agencies so that family support services, such as transportation and respite care, may be accessed on an immediate, emergency basis.

STEPS FOR HOSPITAL-TO-HOME TRANSITION

Step 1 - Identify Potentially Eligible Children

It is recommended that each hospital unit develop a process to identify children potentially eligible for First Steps Early Intervention Services. It is suggested that the individual or individuals chosen for this task be familiar with developmental issues. The First Steps Eligibility Criteria (page 6) should be used to determine whether a referral to First Steps for eligibility determination is appropriate.

Families must have appropriate referrals **prior** to hospital discharge, if the child requires a lengthy hospital stay (especially more than 30 days), has a congenital and/or developmental condition, or low birth weight, or any condition that will require long term medical intervention and services. Timely referral to CHSCS, Medicaid, Social Security, and First Steps are vital, regardless of family income. These referrals allow access to additional financial resources and services. If the referral is made prior to discharge for a child, expected to be hospitalized for more than 30 days, the family's income and resources are waived and only the child's resources considered.

Step 2. Refer Eligible Children to First Steps

Once it is determined that a referral to First Steps is appropriate, the referral should be made within two working days, (470 IAC 3.1-6-3). Parental permission is not required for referral, however, discussion with the family about the intent to refer and the benefits of utilizing First Steps services is considered best practice. The ***Infant Referral Notification*** is sent to the System Point of Entry (SPOE), and the child's primary care physician. The First Steps SPOE representative will then contact the family to determine their interest in participating in services and identifying any family needs for community support prior to the child's discharge. If the family wishes to pursue services with the First Steps system, the SPOE Intake Coordinator will begin the eligibility determination process. The First Steps Intake Service Coordinator has the responsibility to coordinate services with the primary care physician and provide families with information about all relevant community options.

Step 3. Facilitate the Transition from Hospital to Home

Each county's Local Planning and Coordinating Council (LPCC) should have a systematic plan in collaboration with local and regional hospitals to facilitate the transition from hospital to home. Each LPCC has a designated system point of entry for all referrals. A list containing all county's System Point of Entry locations and contacts should be made available to hospital referral sources. The SPOEs and hospitals, in partnership with the families, can identify individuals to support families during this transition.

Step 4. Support the Family Role in Transition Planning

Each hospital and SPOE should establish a process for developing transition plans for eligible children, with their families, and family members or designated caregivers, such as grandparents or foster parents, have opportunities for full participation as equal partners in formulating a plan for the child's transition to the home. The ***First Steps Eligibility Criteria*** has been provided to guide the transition plan.

"I would like the local agencies to contact the families to just say, 'We're here and looking forward to visiting with you. If you have any problems or questions before we meet, don't hesitate to call us.' Once we were out of the hospital's hands, there was a need for professional support."



Step 5. Provide Feedback to the Referring Hospital

Providers naturally want to know that children and families make successful connections with community supports when discharged from the hospital. A **Feedback Report** provides the referring hospital with follow-up information from the receiving provider. The receiving provider, **with parental consent**, is encouraged to provide feedback to the hospital contact person and the infant's physician. This feedback information should be provided after the provider has contacted the family, helped them assess their needs, and either established with them a plan for services or indicated the family has declined to receive services.

"During the transition, we are making a concerted effort to put a 'face and a name' with the community contact person. We have agreed that we want that person involved before the child goes home from the hospital so there is a familiar person. We recognize the ultimate goal is to help the family have some continuity and to make the process as smooth as possible. So we continue the family service coordination throughout the transition process."

First Steps Eligibility Criteria



A. Diagnosed Physical and Mental Conditions (470 IAC 3.1-7-2)

Children from birth through two (2) years of age shall be considered eligible for early intervention services if they have a diagnosed physical or mental condition that has a high probability of resulting in delay. This category includes children who have an identified physical or mental condition but who may not be exhibiting delays in development at the time of diagnosis.

The categories of physical and mental conditions include:

- Chromosomal abnormalities or genetic disorder;
- Neurological disorder;
- Congenital malformation;
- Sensory impairment, including vision and hearing;
- Severe toxic exposure;
- Severe infectious disease; and,
- Atypical development disorder

Eligibility within this category will be determined based on a statement/report signed by a physician or psychologist, as appropriate, indicating the condition which is likely to lead to developmental delay.

The child's multidisciplinary evaluation and assessment must result in a determination that the identified condition(s) is associated with developmental concerns, and that early intervention services would be appropriate to meet the needs of the child. This determination will be based on informed clinical opinion, not on a specific diagnosis only.

B. Development Delay (470 IAC 3.1-7-1)

Children who are developmentally delayed are those from birth through age two years who are experiencing delays, as measured by appropriate diagnostic procedures and instruments, in one or more of the following areas:

- cognitive development;
- physical development, including vision and hearing;
- communication development;
- social or emotional development; or,
- adaptive development.

Documentation of delay may be established by the use of one of the following procedures:

1. Informed Clinical Opinion

When relying on informed clinical opinion for establishing eligibility, delay may be determined by a consensus of a multidisciplinary team, including the parent(s), using multiple sources of information including, at a minimum, the following:

- a developmental history as currently reported by the parent(s) or primary caregiver;
- a review of pertinent records related to the child's current health status and medical history with possible consideration given for functional status, recent rate of change, and prognosis for change in the near future based on anticipated medical or health factors, and;
- at least one (1) other assessment procedure to document delayed development, such as observational assessment or planned observation of a child's behavior and parent-child interaction or documentation of delayed development by use of non-standardized assessment devices, such as developmental checklists.

2. Standardized Assessments

When using standardized assessments of criterion-referenced measures (age and disability appropriate) to establish eligibility, a developmental delay is defined as:

- a delay in one area of development as determined by:
 - (I) one and one-half (1.5) standard deviation below the mean; or
 - (II) twenty percent (20%) or more in function below the chronological age (adjusted for prematurity, if applicable) on an assessment instrument that yields scores in months; or
- a delay in two or more areas of development as determined by:
 - (I) one standard deviation below the mean; or
 - (II) fifteen percent (15%) or more in function below the chronological age (adjusted for prematurity, if applicable) on an assessment instrument that yields scores in months.

C. Biologically At-Risk (470 IAC 3.1-7-3)

Children birth through two (2) years of age shall be considered eligible to receive early intervention services if they are at risk of having substantial developmental delays if early intervention services are not provided due to known biological factors. The biological risk factors that are considered when establishing eligibility for early intervention services include the following:

- Limited Prenatal Care - This risk factor refers to pregnant mothers who have had four or fewer obstetrical visits prior to the 34th week of pregnancy or whose prenatal care was initiated in the third trimester.
- Maternal Prenatal Substance Abuse - This risk factor refers to regular maternal use of tobacco, alcohol (more than one drink per day), or illicit and prescription drugs known to affect the developing fetus during pregnancy.
- Severe Prenatal Complications - This risk factor refers to complications during pregnancy known to potentially compromise neonatal outcomes. Examples of such complications include moderate to severe toxemia, placenta previa, abruptio placentae, lead exposure, or such maternal illness as diabetes or rubella.
- Severe Perinatal Complications - This risk factor refers to severe complications in the birth and postpartum period, such as prematurity (32 weeks gestation) or respiratory distress syndrome. This risk factor would not be used in conjunction with another risk factor, low birth weight (less than 1500 grams), unless there are severe perinatal complications other than prematurity or respiratory distress which describe the infant.
- Asphyxia - This risk factor refers to a particular cluster of clinical signs which indicate that a reduction in the oxygen level below the physiological requirements of the infant has occurred (Amiel-Tison & Ellison, 1986; Blackman, 1989; Brann, 1986; Broman, 1979). The clinical signs of asphyxia include fetal distress (i.e., abnormal heartbeat patterns, and/or the passage of meconium) and neonatal distress (e.g., poor color, poor muscle tone, failure to breathe spontaneously as typically assessed by the Apgar scores used to designate the occurrence of asphyxia). To interpret a low Apgar (i.e., at least 5 as indicative of asphyxia) other signs known to occur during intrapartum asphyxia must also be present (i.e., fetal distress or passage of meconium). Symptoms in the infant that indicate that asphyxia occurred are: lethargy (abnormal state of consciousness), seizures, abnormal muscle tone, poor feeding and abnormal reflexes. Thus, the most accurate assessment that an infant has been asphyxiated is based on an indication of fetal distress in conjunction with evidence of immediate neonatal distress and signs of CNS abnormality.
- Very Low Birth Weight - This risk factor refers to premature infants whose birth weight is less than 1500 grams or 3.3 lbs.
- Small for Gestational Age (SGA) - This risk factor refers to infants whose birth weights are abnormally small for their gestational age. Researchers have been very consistent in defining abnormally small as having a birth weight below the 10th percentile for gestational age on one of several sets of sex-specific norms for that population (Klebanoff, Meirik & Berenedes, 1989; Neligan, Kolvin, Scott & Garside, 1976; Parkinson, Scrivener, Graves, Bunton & Harvey, 1986). This term can refer to premature or full-term infants.
- Severe Postnatal Complications - Severe postnatal complications (e.g., catastrophic infections, growth deficiencies/nutritional problems).