

# Examples of Excellence

## **St. Peter's Home Care Improves Communication, Resulting in More Efficient Transitional Care Coordination**



**St. Peter's**  
HEALTH CARE SERVICES

Based in Albany, N.Y., St. Peter's Home Care is a division of St. Peter's Health Care Services. The culture throughout the organization is one of constant improvement, so it's no surprise that St. Peter's Home Care has a Continuous Quality Improvement (CQI) team, constantly looking for ways to improve the services they provide. The CQI team, a multidisciplinary team made up of 12 home care employees, noticed that referrals were not always complete and that communication throughout patient transitions was not as good as it could be. The CQI team saw an opportunity for improvement!

The CQI team brainstormed ideas to improve communication at the time of patient transfers. A sub-group of the team headed by the CQI chairperson was formed to meet with discharge planners and operations managers in acute care to look closely at the transition process and how it could be improved.

The St. Peter's Home Care team decided to use a target population for implementing any changes in transitional care. Since the U.S. Department of Health and Human Services (DHHS) was in the midst of a big push to improve cardio management, the team decided to focus on the congestive heart failure (CHF) population. The project rapidly developed from a communication process into a cross-setting care delivery model.

St. Peter's Home Care focused its education on promoting self management and providing consistency across settings in what patients were being taught. The team worked hard to make sure patients heard the same message from their hospital, home care, physician office and other involved care settings, answering questions and conveying educational material in the same manner. The team also developed an interactive patient education/discharge sheet and incorporated it into the discharge process from acute care to ensure consistency in communication to the patient in transition between settings.

Being structured as a department of St. Peter's Hospital has been an advantage in the operational implementation of the project. St. Peter's Home Care, in collaboration with members of the St. Peter's Hospital heart failure specialist team, developed a patient education notebook, divided into two sections: education and a monthly calendar. The notebook is intended for patient's to carry with them to various health care visits and share with the different health care providers. By doing so, communication between the health care providers would improve and each would know what type of care had been provided previously.

The patient education notebook is given to all hospital patients, which they then share with their physician or home health nurse. However, if a new patient comes to St. Peter's Home Care from an outside facility, the notebook is provided to them and then the patient is encouraged to share with it their various health care providers.

Other tools were also developed, including standardized orders for admissions, parameters for physician notification and a CHF-specific telephone follow-up form. During Congestive Heart Awareness Month (April) 2006, St. Peter's held a kick-off campaign. Along with implementing the patient notebook and offering education, a dietician was offered to every CHF patient – in a standardized approach.

The results have been noteworthy! St. Peter's Home Care had a five percent decrease in their acute care hospitalization (ACH) rate for the CHF population, dropping from 20 percent (April 2005) to 15 percent (December 2006). There has been a significant impact on patient self-management and satisfaction. Patient surveys revealed 90.9 percent (Q2 2007) of CHF patients feel confident that they can manage their care and take care of themselves, up from 83 percent (April 2006). There was also an increase in the measure of patient satisfaction with the overall quality of care and services, which went from 94 percent (April 2006) to 100 percent (Q4 2007).

Recently, the project was taken a step further when the New York Quality Improvement Organization, IPRO, hosted an Institute for Healthcare Improvement (IHI) home care driven collaborative on care transitions. The six-week cross-setting collaboration included two other home care agencies along with St. Peter's Home Care. Involvement in this initiative provided opportunities for further learning and sharing of best practices. For instance, the "teach-back" method has been adopted to ensure patient comprehension of instructions given.

With the targeted improvements achieved, St. Peter's Home Care now has plans to use the same methodology with their chronic obstructive pulmonary disease (COPD) population in 2008.

"Communication is the key to consistency of patient care," said Carol Ann Thomas, Manager of Patient Safety and Quality Improvement at St. Peter's Home Care. "This undertaking taught us to look at all sides of patient care – not just the home care perspective. It is not a one-sided process."

*Data in this article was provided by Carol Ann Thomas at St. Peter's Home Care.*

