Monthly meetings help Seton Home Health reduce rehospitalization rates

Two years ago Seton Home Health in eastern New York began holding monthly meetings to involve team members across the continuum of care.

Seton began working with IPRO, the state's federally designated Quality Improvement Organization, to improve patient care transitions between hospital, home care, and nursing home providers. The home health agency is part of Seton Health's hospital-based system, but that didn't mean the two fully understood each others' roles.

"The things we are doing may seem simple," said Susan Ambrosy, Quality Manager for home health, "but we had been working in silos in which nursing homes, hospitals and home care were each in its own silo. Now we are working with each other."

The first step was monthly meetings that brought together as many of the key players as possible. Besides the home health agency personnel, the meetings include the hospital's pharmacists and case managers, as well as a representative for palliative care. Nurses who champion the program attend, along with community faith-based nurses. The hospitalists are also part of the team. When possible, the system's information technology professionals attend to bring their computer expertise to the mix, Ambrosy said.

"Just by meeting, we've increased our understanding of each others' roles and challenges, and that in itself breaks down the silos," she said.

Everyone better understands the importance of caring for the patient across the continuum, she said. In fact, during these meetings the hospital staff will now ask the home health team what's going on at the patient's home.

As a result of the meetings, information systems created an electronic referral to simplify the transfer from the hospital to home health. The new program pulls basic information, along with vital information such as wound care, from the nursing notes and the electronic record to populate the fields for the home health agency, Ambrosy explained.

The meetings also offer an opportunity to discuss ways to improve medication reconciliation across the continuum of care. One change that came about is that a pharmacist now reviews the medication list of each home care patient and removes hospital medications that have been discontinued.

Several other changes also came out of the meetings, including the following:

- The hospital now sets up an appointment with a patient's primary care physician within seven days of being released.
- The hospital informs the home health agency about patients who are at a high risk for falls.
- The hospital helps make sure the non-hospital DNR form is signed before the patient is discharged since New York has a non-hospital DNR form as well as one for hospitals.

Ambrosy said it's important to realize that patients see the home health agency and the hospital as one and the same and don't understand why there might be a lack of communication between the two.

"The better information you get from the hospital, the better the patient sees you," she said.

For its efforts to improve care transitions, the Seton health care system received the IPRO quality award in June. The hospital reduced its rehospitalization rate by 6 percent, while the home care agency's rate decreased by 30 percent, Ambrosy said, based on the Medicare claims data as provided by IPRO.

"We didn't get a grant or any additional money for this project," said Ambrosy about implementing the award-winning initiative, which did increase the workload. "But it is definitely worth doing because it is in the best interest of the patient."