Coordination of Care Best Practices: Managing the Transition between Acute and Home Health Care

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Truly suffering from the illness experience, patients and their families need every interaction to support, affirm, and help them on their road to recovery. Or help improve their physical, mental, and emotional pain when recovery is not possible. This means evaluating and designing every process with this in mind not just in hospital but also in the transition to home care services.

Patients want:

- To have their follow-up and home care seamlessly arranged.
- To have the information needed to have true confidence in their feeling of preparedness for going home and caring for themselves in the days after discharge.
- To have a convenient, easy, fast, and pain-free transition from their hospital bed to their home.
- To have all their questions answered, their feelings considered, their family involved, enough flexibility in the process to adjust to their individual needs, and a continuous healing relationship with all the care providers.

To achieve this, there must be a seamless transition from acute care to home care. This involves effective and respectful communication from nurses, doctors, and the home care team that interacts with patients and their family members. The February 2008 Satisfaction Snapshot profiles best practice in managing the transition process.
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Executive Summary

As health care systems grow in size and complexity, achieving a consistently high-quality patient care experience is dependent on coordinating care across multiple health care delivery settings. The transition from inpatient care to home health care provides a great opportunity to improve this care coordination.

A patient’s clinical outcome and your organisation’s reputation will be affected by your patients’ experiences in transitioning from inpatient acute care to subacute care, such as home health, assisted living, or inpatient or outpatient rehabilitation, especially if the entities operate under the same name. Opportunities for improvement exist in coordination of care with affiliated and non-affiliated home health providers. Hospitals and home health providers desire a positive outcome for their patients and improved image in both the eyes of the patients for whom they care and the surrounding community.

The transition from acute care to home health care continues to challenge providers. Home health care patient volume is growing nationally and projected to continue its significant growth because:

- It costs significantly less to care for a patient with similar conditions/illness in a home health care environment than in an inpatient, assisted living, or nursing home setting. This means that large integrated health systems, insurers, and the federal or state government (as a payor) find it in their best economic interests to push patient volumes to home health. This is evidenced in continued declines in acute care lengths of stay and the fact that home health care is the fastest-growing health care sector (Borger et. al. 2006).

- Private spending for home health care continues to grow. Most patients simply prefer to be cared for at home instead of a medical facility.

- Patient care complexity, co-morbidities, and the elderly and advanced elderly populations are all on the rise.

This paper reports the results of qualitative interviews to determine best practices among acute care hospitals and home health care agencies that outperformed nearly all other organisations in Press Ganey's international databases on coordination of care-related measures.

Those organisations are:

- Gulf Breeze Hospital (Gulf Breeze, FL)
- Floyd Valley Hospital (Lemars, IA)
- Souhegan Home & Hospice Care (Milford, NH)
- Avera Holy Family Hospital (Estherville, IA)
- Home Therapeutics (Brisbane, QLD)

These organisations shared three common themes in their approaches to managing the transition process between acute and home health care. They concentrated efforts on the following tactics:

1. Organisation-wide emphasis on customer satisfaction
2. Frequent, effective communication
3. Use of information-sharing technology
These themes may appear obvious, but the true performance differentiator lies in execution. In this paper, we explore how inpatient acute care facilities and home health agencies relentlessly and effectively implemented these tactics. Although this paper focuses on the transition between inpatient acute care and home health care, the underlying lessons for service quality and coordination of care apply to any setting.

**Home Health Care Industry Growth Trends**

The projected rapid growth in home health care makes it imperative all organisations working with home health care agencies hone their coordination of care practices across traditional organisational boundaries.

“In the US, Public spending now accounts for 75 percent of all home health spending; it is projected to top 80 percent in 2015, when spending on home health is projected to reach $103.7 billion. Although home health is a relatively small percentage of the total national health care bill, it represents the fastest-growing health care sector.”

“According to Forrester Research, the home health industry in the US is projected to be a $2 billion industry by 2008, skyrocketing to $28 billion by 2020.”
http://www.healthpolitics.org/homehealthcare_hrc.asp
INTRODUCTION

Health care is typically delivered in silos. Individual, distinct experts apply their skills to meeting a precise patient need. While this division of labour proves an effective approach to many health service delivery situations, the weaknesses are especially apparent during the discharge process from an inpatient facility. Many times, the individual care providers do not communicate as often or as effectively as necessary for a smooth and safe transition (Kripalani et. al. 2007). Health care providers do not automatically know how to work in an integrated environment and are often unaware of its benefits (Callahan et. al. 1999). Yet, coordination during a transition process is critical to preventing relapses and readmission. Transitional care programs typically have not been adopted because of lack of direct Medicare or health insurance reimbursement, the system’s focus on acute versus chronic care, and the organisation of care into distinct silos such as hospitals or home care without explicit connections between them (NIH 2004).

During the discharge process, coordination of acute to home health services is essential to the health of patients as well as to the health of the organisation. A patient's transition from an inpatient facility to a home health setting is complex at best. When employees from both organisations collaborate in this process, the result is healthier patients and higher patient satisfaction and loyalty for both the inpatient facilities and home health agencies. Acute care facilities and home health agencies can positively impact their patients' satisfaction by collaborating, communicating and providing the highest level of service to patients. The collaborating organisations, as well as their patients, benefit from these efforts.

Benefits to Patients and Their Families

Coordination of care is particularly important with regard to patient-centred initiatives. “When acute- and chronic-care services are truly integrated, somebody knows you and cares what happens to you.” (Callahan et. al. 1999) When patients receive personalised attention, they recognise this care and are more satisfied as a result. Furthermore, in this care environment, patients have a voice. Their needs are better met and the entire system is more aligned with patient-centred care initiatives.

When the organisations delivering care communicate effectively, less responsibility falls onto the patient to manage the process. “In the majority of care transitions, the patient and caregiver are the only common thread between sites of care and by default have been given the added responsibility of facilitating their care transitions, often without the necessary skills or confidence to do so.” (Callahan et. al. 1999) With the burden patients and their families experience during an acute or rehabilitative illness, the last thing they should worry about is the logistics of their care. Care providers are in a much better position to manage the logistics of the transition process. In an integrated care delivery system, the client moves smoothly from one setting to another based on need, not reimbursement rules. A closely related benefit is peace of mind for family members and others who otherwise must scramble to bridge the gaps in care, and who worry when they cannot.

Synchronising care between an acute care setting and home health also improves clinical quality. Researchers from Harvard Medical School and the University of Ottawa reported that nearly 20 percent of 400 patients in their study were victims of an “adverse event” that occurred after discharge and resulted from the care they received rather than an underlying disease or condition (Boodman 2003). Their study suggests that better coordination can reduce medical errors related to the transition of care.

Benefits to Inpatient Facilities

When inpatient facilities collaborate with home health agencies outside their organisations, the inpatient facilities realise an improvement in patient satisfaction scores specifically related to the Press Ganey survey question “Help with arranging home care services (if needed).” The reality is, if the arrangements made for patients fall through, don’t match patients’ needs and expectations, or are of poor quality, patients will point the finger at the inpatient facility. Ultimately, achievement of high patient satisfaction and loyalty to an inpatient facility depend on these final impressions. Therefore, inpatient facilities have a vested interest in ensuring a successful patient experience (Clark 2006).
An additional benefit to consistent communication between inpatient facilities and home health organisations is that it fosters relationship building. When trust develops between two organisations, their working relationship improves. Each positive interaction the two organisations share makes the process that much more effective the next time. The patients’ perceptions about both organisations improve, as do patient satisfaction scores.

Benefits to Home Health Agencies

Home health agencies, too, reap the rewards of successful case management by collaborating with inpatient facilities while transitioning a patient to their care. Patient satisfaction scores are, no doubt, influenced by patients’ discharge process experiences, and a smooth transition leads to higher patient satisfaction scores.

Additionally, home health agencies can generate future business opportunities as the result of a smooth transition process. Word-of-mouth from friends and family is one of the primary ways patients select their care providers (Kaiser Family Foundation & AHRQ, 2000). As a patient, the negative and positive experiences of friends and family are likely to influence the selection of a home health agency.

When inpatient facilities and home health agencies collaborate, they are more likely to consider how each organisation’s actions affect the other. Each organisation is more aware of and respectful of how its work will affect the other and, ultimately, patient care. In addition, collaboration promotes a greater understanding of care to be provided to the patient. It also encourages inter-organisation contact if the home health agency has questions about the care regimen.

BEST PRACTICES

We interviewed organisations that performed well in response to Press Ganey patient satisfaction survey questions about the transition of care between inpatient and home health facilities. Three common areas were identified in which top performing organisations excel. By focusing on QI efforts, the organisations are able to achieve and maintain patient satisfaction scores in the top decile of all Press Ganey clients. These areas are:

1. Organisation-wide emphasis on customer satisfaction
2. Frequent, effective communication
3. Use of information-sharing technology

Customer Satisfaction

Organisations that effectively manage the transition from acute to home health care place a strong organisation-wide emphasis on customer satisfaction. They strive to service both the patient and the organisation. Thriving organisations emphasise the importance of the customer or patient -- from new employee orientation throughout day-to-day activities. Customer service activities include home health agencies visiting patients in the hospital prior to discharge, and inpatient facilities providing contact information to the home health nurse so he/she can directly contact someone on the acute side if questions regarding patient care arise. Home health agencies exemplify customer service by seeing patients seven days a week -- when it is convenient for the patient, not just the agency. Organisations that are patient-outcomes focused provide better customer service.

Communication

For the purposes of the inpatient/home health transition, communication refers to an organisation’s ability to manage patients’ expectations by thoroughly addressing their questions and needs. Communication is essential during a patient’s stay in the hospital and extends after discharge. Organisations that are consistently reaching best-in-class results implement a consistent process to call the patient 24 - 48 hours after discharge.

Successful organisations also support regular communication between the discharge planner and intake coordinator. A strong relationship between these two roles at their respective organisations fosters a better transition for the patient. Vital information is less likely to fall through the cracks when members of both organisations are tracking a patient’s progress, and have a strong communication line to access when questions arise regarding care.
Information-Sharing Technology

The information age in which we live enables organisations to more competently manage the transition process from acute to home health care. Before the days of automated referrals, discharge planners would often fax paper copies of medical information from patients’ charts to the intake coordinator at a specific referral home health facility. Automated discharge technology provides patients with a customised discharge packet quickly. Automated referral technology enables staff to send medical information electronically to several potential home health agencies. This saves time and reduces the potential for errors that can occur while passing patients’ medical information between care providers.

Additionally, the birth of the electronic medical record (EMR) enables faster, more accurate information-sharing among care providers. Whether within an organisation or between different care providing organisations, this reduces the likelihood of waiting sometimes weeks for staff to locate paper charts that have been lost or misfiled.

All of these interventions combined work together to improve the transition from inpatient care to home health.
In response to the Press Ganey Inpatient survey question “Help with arranging home services (if needed),” the following organisations realised commendable patient satisfaction scores. They did so as a result of improvement initiatives focusing on the transition process from inpatient to home health.

<table>
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<tr>
<th>Best Practice</th>
<th>Gulf Breeze Hospital</th>
<th>Floyd Valley Hospital</th>
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<tr>
<td>Customer</td>
<td>• To manage patient expectations with their home care, extensive patient education is provided about home health services.</td>
<td>• Families are given the name and contact number of the discharge planner should questions arise after they leave the hospital.</td>
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<td>Satisfaction</td>
<td>• Information is also provided regarding personal care services beyond home health.</td>
<td>• Patients are provided with a community resource list that includes information about Meals on Wheels, Lifeline, and other community services.</td>
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<tr>
<td></td>
<td>• Families are given the name and contact number of the discharge planner should questions arise after they leave the hospital.</td>
<td>• Service standards have been implemented throughout the facility.</td>
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<td>Communication</td>
<td>• Discharge planners double-check the location to where a patient is to be discharged and billing information, prior to forwarding the information to the home health agency.</td>
<td>• Home health agencies all receive copies of the patient’s demographic sheet and discharge instructions.</td>
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<td></td>
<td>• Discharge planners share all clinical and social information with the home health agency to help staff better prepare for the patient’s unique needs.</td>
<td>• The discharge instructions include all medication information and a list of scheduled follow-up appointments.</td>
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<tr>
<td>Use of IT</td>
<td>• The referral process is streamlined though an electronic discharge referral system.</td>
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<td></td>
<td>• The electronic referral system reduces the amount of time required of the discharge planner to coordinate the referral.</td>
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The following home health organisations have achieved top-decile patient satisfaction scores in response to the Press Ganey Home Health survey question “Helpfulness of the person who made the initial arrangements for your services.” They have done so by emphasising three core areas identified earlier in this paper: customer satisfaction, communication, and the use of information technology.

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<th>Best Practice</th>
<th>Souhegan Home and Hospice Care</th>
<th>Avera Holy Family Hospital</th>
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<tr>
<td><strong>Customer Satisfaction</strong></td>
<td>• Culture driven by patient outcomes. Time is dedicated at each monthly staff meeting to discuss current performance. &lt;br&gt; • Staff work closely with the patient and his/her family to take a complete medical and social history.</td>
<td>• Home health care workers visit the patient while still in the hospital. This applies to both in-house and patients from other facilities. &lt;br&gt; • The manager of home health also contacts the patient the day of discharge to address any questions or concerns. &lt;br&gt; • Patients are seen by home health care workers within 24 hours of discharge, regardless of the day of discharge. &lt;br&gt; • The first home health visit is scheduled based on patient preferences, not the home health agency’s schedule. &lt;br&gt; • Home health visits are front-loaded. (i.e. a patient may be initially scheduled for twice-a-week visits but will be seen three times in the first week to make a smooth transition). The initial visit is followed by a next-day visit.</td>
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<td><strong>Communication &amp; Use of IT</strong></td>
<td>• The agency gathers as much information regarding the patient as possible from the referral source. &lt;br&gt; • A conscious effort is made not to overburden referral sources. The agency gathers any additional information after the patient is transferred. &lt;br&gt; • A progressive new orientation program rigorously trains new staff on the importance of patient outcomes and customer service. &lt;br&gt; • All new employees spend two days with the Process Improvement Coordinator, where they learn about the mission and history of the organisation. &lt;br&gt; • Patient-oriented goals are explained in detail during the new employee orientation.</td>
<td>• Avera Home Health is at the same site as the hospital. This makes for easier communication between departments. &lt;br&gt; • The home health manager meets with discharge planners from other hospitals to improve coordination of care. &lt;br&gt; • The introduction of the electronic medical record (EMR) makes it possible for home health staff to have access to a patient’s medical record prior to discharge. &lt;br&gt; • The home health secretary speeds up the process by accessing all necessary information upon receipt of a patient referral.</td>
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### BEST PRACTICES - HOME THERAPEUTICS

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<th>Home Therapeutics</th>
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| Customer Satisfaction                 | • Home Therapeutics understands that lowering anxiety is a major contributor in improving clinical outcome and achieving high satisfaction. The agency strives to ensure that at every stage in the process the patient/client feels supported and informed.  
  • Information is provided to patients, via discharge facilitators that explain the services, patient rights and responsibilities, medication forms and potential care plans.  
  • Compassionate caring and a focus on the continual communication of timeframes to patients has led to high and sustained satisfaction outcomes.                                                                                     |
| Communication & Use of IT             | • Home Therapeutics utilises a web-based referral program which is accessed on the referring facility ward computer. The referring staff member completes an electronic form and submits to Home Therapeutics. The agency receives the referral form via email, accepts the referral and the data is imported into an electronic patient database.  
  • For many clients, Home Therapeutics staff perform a liaison role where potential transitioning patients are met in person, a mutual assessment as to suitability is made and a care plan developed.  
  • The referral system incorporates “safety flags” to alert staff that further input is required from hospital staff. Systems exist for patient assessment, variances recorded and changes to care implemented in collaboration with the referring medical officer.  
  • The agency integrates the use of pathways, detailed reporting back to the hospital or Doctor, and 24 hour on-call support.  
  • A phone call to follow up 24 hours post treatment is made to clients identified as “at-risk” clients such as clients who are recipients of blood transfusions and chemotherapy. A similar process occurs for clients individually identified as ‘at-risk’ by their treating nurse. |
ABOUT THE PARTICIPANTS

**Gulf Breeze Hospital (Gulf Breeze, FL)**
Gulf Breeze Hospital is a 60-bed acute care hospital offering both private and semi-private rooms and a four-bed intensive care unit. It is an affiliate of Baptist Health Care. Patients perceive the survey question regarding help arranging home care services as pertaining to all services, products, and issues related to their health care immediately following hospitalisation.

**Floyd Valley Hospital (Le Mars, IA)**
Floyd Valley Hospital was founded on December 1, 1966, as a General Hospital owned by the City of Le Mars and operated for the benefit of the residents of the communities in the Floyd Valley area. The hospital currently has 25 beds. It is an affiliate of Avera Health Network of Sioux Falls, SD. In 1990, after health care saw a dramatic shift from inpatient to outpatient and home care, Floyd Valley Hospital Community Health Services was formed to bring health services into the home.

**Souhegan Home and & Hospice Care (Miford, NH)**
Souhegan Home & Hospice care has been providing quality and compassionate care for more than 50 years. It is affiliated with St. Joseph Hospital, based in Nashua, NH. It works to assist its clients in gaining dignity and self-respect, while promoting independence. Souhegan employs an on-call agency nurse and has services available 24 hours a day, seven days a week.

**Avera Holy Family Hospital (Estherville, IA)**
Holy Family Hospital was established in 1944 and Estherville Medical Clinic in 1975. In 1997, Estherville Medical Clinic relocated to the Avera Holy Family Health campus to begin a partnership of integrated health services. Avera Holy Family Hospital’s services now include a home health agency that is located on the hospital campus.

**Home Therapeutics Pty Ltd (Brisbane, Queensland)**
Home Therapeutics is a specialised home health service provider based in Brisbane. The company is a leader in the field of home based intravenous and related therapy, delivering advanced home-based clinical care, patient education and support. Having alliances with numerous public & private hospitals and Doctor practices, the company has developed innovative strategies to effectively make the care transition process, from acute to home, one that ensures the patient is completed supported.

CONCLUSION

The overall health of an organisation is indicated in part by its patient satisfaction scores. Acute care facilities and home health agencies have an opportunity to improve their patient satisfaction scores by working together to facilitate the transition from acute to home health care.

High-performing organisations concentrate their transition efforts on three specific areas:

1. Organisation-wide emphasis on customer satisfaction
2. Frequent, effective communication
3. Use of information-sharing technology

Health care providers can identify areas of opportunity for improving this transition by combining the results of the discharge section of the inpatient satisfaction survey with the arranging home care services section of the home health survey. It takes the combined efforts of both hospitals and home health providers to effectively manage the transition. Neither team can do it alone, but together they can make the transition more seamless for the patient.
REFERENCES


