A black dotted line graphic that starts at the bottom of the hospital icon, goes right, then up, then right again, and finally down to the top of the home icon, forming a path that connects the two locations.

transitions from hospital to home

patient and caregiver
priorities

Health Quality
Ontario

Let's make our health system healthier



In early 2018, Health Quality Ontario asked Ontarians about their transitions from hospital to home. Various patients and caregivers shared many stories of success. They received compassionate care that eased the journey home, and they had the right supports in place once they arrived.

We also heard about gaps in care—challenges with the discharge process, medications, home care and follow-up appointments, to name a few. We heard simple stories, moving stories, and stories that were complex.

What we heard was only the beginning.

Next, we wanted to understand what parts of transitions back home are most important to Ontarians. What's needed to improve their transitions in care?

Later in 2018, we asked once again and you responded.

This is what we learned.

What we asked

From the more than 600 original stories you shared, we then worked with patient partners and community advisors to review the stories and identify what parts of the transition matter to patients and caregivers. We found 52 points in the journey from hospital to home that can make a difference. These points touch all aspects of a patient's transition: from cost to coordination, from medications to medical follow-up.

We then asked Ontarians to rate these 52 points in the transition process. Which points would have the biggest impact on your confidence to care for yourself or your loved one? And which points in the transition represented a gap that the health care system should address first?

What we learned

Close to 300 people shared their priorities in person and online. From patients and caregivers, from the elderly to those caring for children, from rural Ontarians to city people—we learned that many Ontarians share the same priorities for improving their transitions from hospital to home.

Three key insights emerged from learning about your priorities:



Home care is a top priority



Some groups face unique challenges



Caregivers play a special role that needs to be acknowledged



Insight 1: home care is a top priority

Home care stood out as a priority for all. For people with diverse health needs and from different communities across Ontario, improving home care resonated the most.

Three of the top five priorities that emerged, across all aspects of transitions in care, focused on home care: **funding for home care, access to home care, and timeliness of starting home care.**

“

The social worker made arrangements for home care/therapy etc. However, it took some time and a lot of advocating for those initiatives to be put in place and it was very stressful for both my relative and me as the sole caregiver.

“

We were quite impressed by the flexibility the home care coordinator showed, for instance moving around the hours of care as we all figured out the new normal at home.



Insight 2:

some groups face unique challenges

Some groups of people highlighted unique challenges they face in their transitions from hospital to home.

Examples include:

- People living outside urban areas would like it to be easier to fill a prescription quickly after they are discharged from hospital
- People who received care for mental health conditions would like to improve the chance to be heard and to ask questions in hospital; more than other patients, their experience while in hospital affected the transition home
- People living in poverty find it hard to manage the out-of-pocket costs of health supports in the community such as physiotherapy, occupational therapy, and medicines

Understanding the unique challenges faced by people in different circumstances is important to make sure transitions work for all. And addressing gaps in care like these may help people across Ontario be as healthy as possible, regardless of their unique challenges.



Insight 3: caregivers play a special role that needs to be acknowledged

From across Ontario, all kinds of caregivers—family members and friends—spoke of their own special challenges and priorities. Whether young or old, caregivers want to be heard, to be a part of decision-making around the patient’s care, and to ease the patient’s transition home.

Some of their priorities are:

- Making sure home care is in place when the patient leaves the hospital
- Making sure hospital staff involved in discharge planning do not assume family and friends will provide care at a certain level of ability or for a certain amount of time

“*After providing support and meds to my husband every 4 hours round the clock, I was exhausted after 3 Days. How do people cope doing this for months at a time?*”

“*The doctor included us in all decision making and steps. When I asked him what he would do if it was his father, he said “the exact same that you and your sister are doing”. Kind and empathetic. Makes all the difference.*”



What's Next?

We have heard from Ontarians about their experiences transitioning from hospital to home.

We have learned from Ontarians what the priorities should be when it comes to making those transitions better.

Now, we are using what we heard and learned to improve the quality of care for Ontarians.

Your priorities helped us develop a provincial standard for high-quality care during transitions from hospital to home. The standard is designed to support health professionals to know what quality care looks like during transitions, and to improve the care patients receive as they leave the hospital and after they return home.

And, it's part of our library of other [Quality Standards](#). All of our standards are based on the best available evidence and are developed in collaboration with patients, family members, and health care providers.

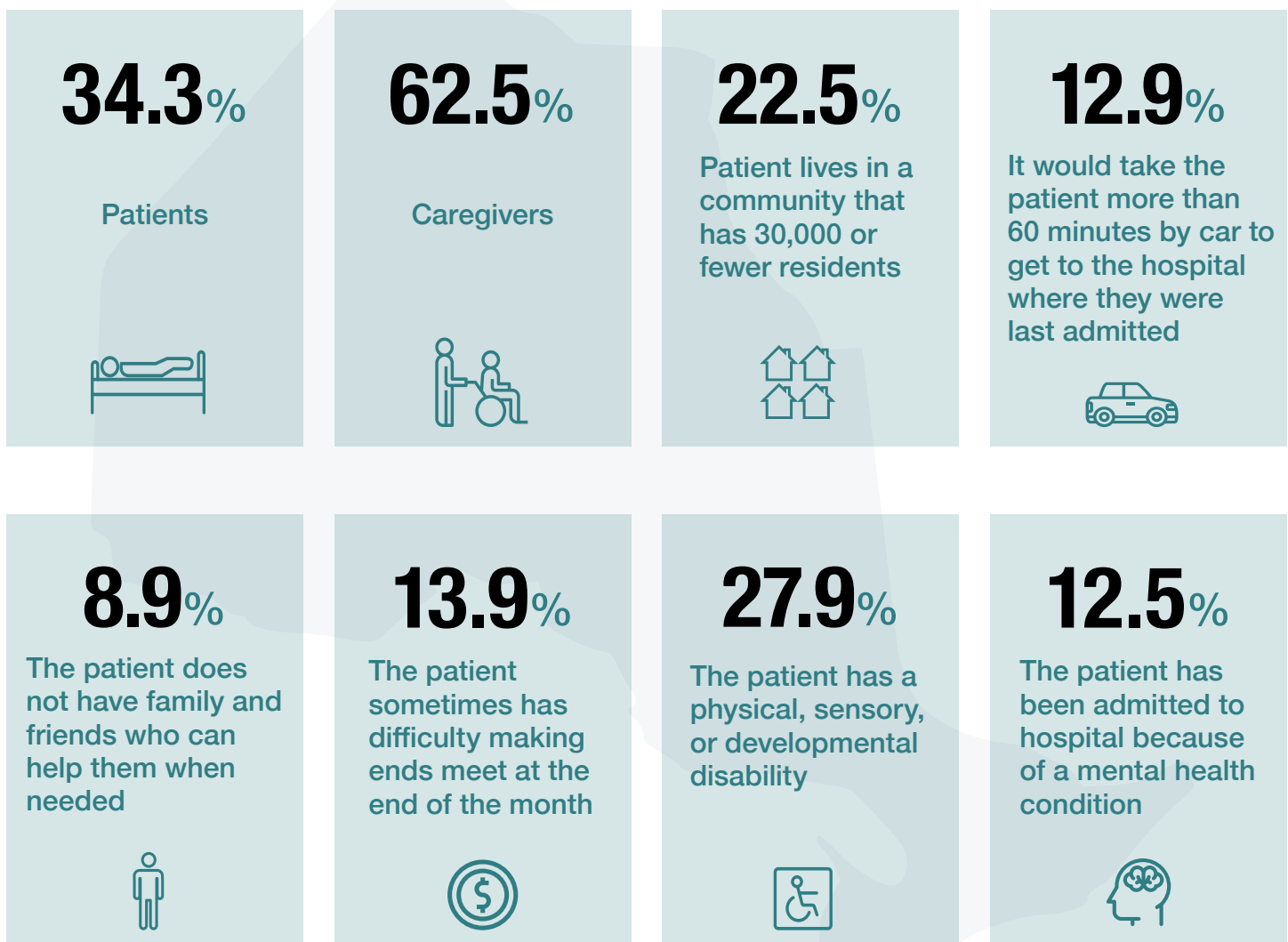
Engagement Approach

To understand Ontarians' priorities among the 52 points in the transition process, Health Quality Ontario's patient partnering team and community advisors reached out to many of the patient groups and health care partners previously involved in sharing stories about the transition from hospital to home. Along with inviting participation online, project members reached out to participants in person.

Participants were able to share their priorities through online or paper surveys.

Who were our participants this part of the project?

These are the experiences of patients and caregivers who participated:



About this Project

Transitioning home after being a patient in a hospital can be challenging. It can be a time of stress for the patient, their family and health care providers too. Poor transitions also increase the risk of complications and can put a strain on the system. We know our health system can do better.

What factors matter most to patients? What affects their transition home?

To answer these questions, Health Quality Ontario, in collaboration with Tara Kiran, a researcher funded by the Canadian Institutes of Health Research, reached across the province to hear from patients, caregivers, and families about their experiences with the transition from hospital to home.

For more information about this project, visit:

hqontario.ca/transitions

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