Transitions Between Hospital and Home

In the Community Post Hospital Stay: Designate a Person in the Community to Support Non-Clinical Needs in the Immediate Post-Hospital Period

Released September 2016

Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up.

Figure 1 is an outline of **innovative practices and evidence-informed best practices** that are designed to improve transitions between hospital and home.

The use of these practices varies significantly across the province. Teams are encouraged to prioritize the implementation of evidence-informed best practices before adoption of the innovative practices outlined in this document. When considering the adoption of innovations, *recommended practices* should be considered first, followed by *promising practices*, and then *emerging practices*.

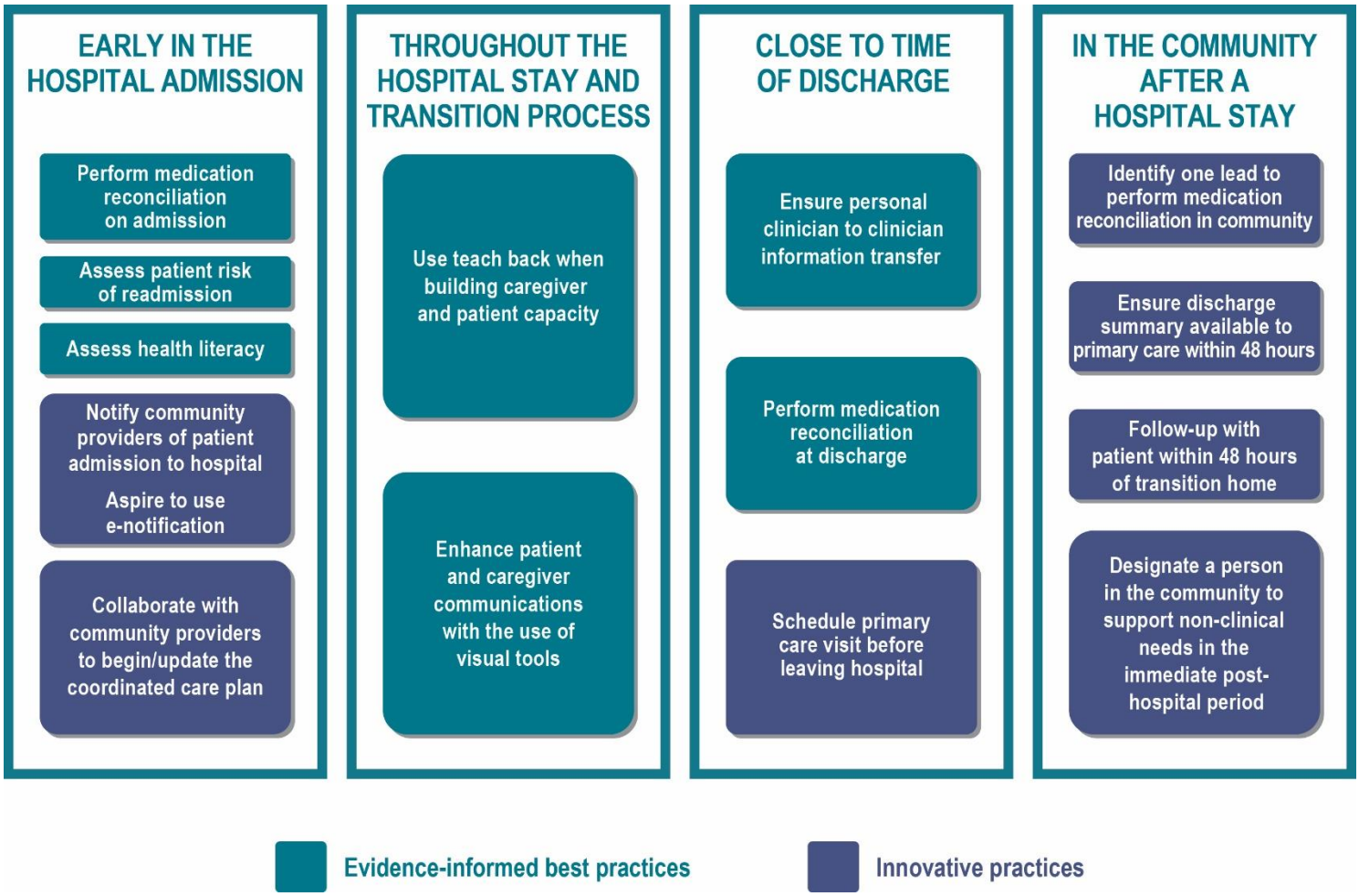

Figure 1: Practices to Improve Transitions Between Hospital and Home

The material for Transitions Between Hospital and Home was developed in collaboration with Health Links and the Clinical Reference Group.

Description of this Innovative Practice

In the post hospital period, patients with multiple conditions and complex needs may need a support person to help support daily living activities such as grocery shopping, home maintenance (e.g., lawn care), booking appointments, getting to appointments, and asking questions during appointments.

Informal caregiver burden is growing in Ontario. Organizations that provide paid or volunteer support in the community can help to reduce informal caregiver burden; however, the cost of these services should not fall on patient or caregivers. In a study that provided patients with non-clinical community health worker (CHW) support, patients expressed appreciation for the social support and often described psychosocial issues as barriers to recovery.[1]

Innovative Practice	Innovative Practice Assessment[2]	Clinical Reference Group Endorsement for Spread
Designate a person in the community to support non clinical needs in the immediate post-hospital period.	EMERGING	Provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (Sept 2017).

Implementation of the Innovative Practice		
Steps for Implementation	**Tools and Resources**	**Considerations**
1. Perform a gap analysis for required home supports During hospital stay, using your clinical judgement, assess the patient's post hospital plan of care and living situation to identify potential gaps that may impact the patient's ability to follow recommended follow-up. (For example, if the patient is recommended to have a low sodium diet, does the patient have the ability to go to a grocery store for fresh supplies and low-sodium options?) ***2. Identify lead or agency/organization that could fill the role*** Working with the single point of contact, identify a lead from potential resources (e.g., family caregivers, community support agencies, regional government agencies, city staff) that will be able to assist with necessary daily tasks. ***3. Connect with circle of care and update the Coordinated Care Plan*** Ensure that the care team is aware of the non-clinical support contact(s) and plans by updating the	Examples from the Field: • **South West LHIN**: ARTIC project describes the Transitional Discharge Model focused on those with mental health as a main concern (http://www.hqontario.ca/Quality-Improvement/Our-Programs/ARTIC/ARTIC-Projects/METAPHI • **Waterloo Wellington LHIN**: Intensive Geriatric Support Worker (IGSW), non-clinical role, for frail seniors (http://seniorfriendlyhospitals.ca/sites/default/files/Senior%20Friendly%20Hospital%20Care%20in%20the%20WW%20LHIN%20%28February%202015%29_0.pdf). • **North Simcoe Muskoka LHIN**: Volunteers provide friendship and support to independent living (http://seniorfriendlyhospitals.ca/sites/default/files/NSM%20LHIN%20SFH%20Summary%20Report_2.pdf)	• Whether it be a paid function, a volunteer function, or a role fulfilled by the patient's identified caregiver, role clarity is vital. Role clarity will ensure all parties are functioning to their full scope and completing the needed tasks for the patient, including communication back to the circle of care.

[1] Kangovi S, Mitra N, Grande D, White M, McCollum S, Sellman J, et al. Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial. JAMA Intern Med. 2014;174(4);535-543.

[2] *For more information about the Innovative Practices Evaluation Framework assessments, please go to the following link: http://www.hqontario.ca/Portals/0/documents/qi/health-links/innovative-practices-evaluation-framework-overview-en.pdf*

Implementation of the Innovative Practice		
Steps for Implementation	**Tools and Resources**	**Considerations**
coordinated care plan and sharing with the circle of care.	• **North East LHIN**: Care workers support discharged patients (mainly older adults) on the journey home (http://www.nelhin.on.ca/Page.aspx?id=16568) • **South West LHIN**: "Home at Last" provides non-clinical transitional support workers (http://www.southwestlhin.on.ca/~/media/sites/sw/uploadedfiles/Public_Community/Aging_at_Home/Project_PDFs_and_Images/HAL%20Placemat%202010-11.pdf)	

Measurement

Quality Improvement Measures are used to help with monitoring progress in implementation of a change and determining whether that change is leading to improvement. Just as a health care provider may monitor heart rate or blood pressure to determine a patient's response to treatment, collecting information relating to processes for the improved provision of care allows the team to know whether they are consistently moving towards a high reliability care environment. *For more information on **Quality Improvement and Measurement** please visit* http://qualitycompass.hqontario.ca/portal/getting-started.

The following measures have been developed to help to determine: 1) if Innovative Practices for Transitions Between Hospital and Home are being ***implemented***; and 2) the impact of these practices on Health Links ***processes*** and the ***outcomes*** of care at the patient, population, or systems level.

Health Links, organizations, and/or providers that elect to implement one or more of the Innovative Practices for Transitions Between Hospital and Home are **strongly encouraged to collect data on the associated measures and report them to Health Quality Ontario**. This will enhance analysis at the next review (Sept 2017), which will benefit all of the Health Links.

Suggested Measurements
(please see Appendix A for additional details)

Suggested Outcome Measures	Suggested Process Measures	Additional Information
1. Caregiver distress related to caring for the needs of a patient with multiple conditions and complex needs in the fourteen (14) day post discharge period*	2. Percentage of patients with multiple conditions and complex needs who have paid or volunteer non-clinical assistance provided without charge to the patient in the immediate post discharge period up to fourteen (14) days 3. Satisfaction of patient who has multiple conditions and complex needs with the involvement of the support person(s) in the community	• Recommend that Health Links collect and report data for a minimum of three (3) months. • QI RAP templates will be available if the Health Link chooses to use them. • All patients who are receiving care through the Health Link are included in the sample. • Consider stratifying measures from an equity lens.

*This indicator is closely aligned to the Common Quality Agenda measure of caregiver distress

References

1. Ho J, Kuluski K, Gill A. A Patient-Centered Transitions Framework for Persons with Complex Chronic Conditions. Care Manag J. 2015;16(3):159-69.
2. Horwitz L. Self-care after hospital discharge: knowledge is not enough. BMJ Qual Saf. 2016 March 8. doi:*10.1136/bmjqs-2015-005187*. [Epub ahead of print]
3. Kangovi S, Mitra N, Grande D, White M, McCollum S, Sellman J, et al. Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial. JAMA Intern Med. 2014;174(4), 535-543.
4. Health Quality Ontario. The Reality of Caring: Distress among the caregivers of home care patients. Toronto: Queen's Printer for Ontario; 2016.

Appendix A:
Measurement Specifications for Designating a Person in the Community to Support Non Clinical Needs in the Immediate Post-Hospital Period

Released September 2016

1. Caregiver distress related to caring for the needs of a patient with multiple conditions and complex needs in the fourteen (14) day post discharge period

Stage of Hospital Stay	In the community post hospital stay
Innovative Practice	Designate a person in the community to support non clinical needs in the immediate post-hospital period
Type of Measure	Outcome Measure
Definition/Description	In the post hospital period, patients with multiple conditions and complex needs may need a support person to help support daily living activities such as grocery shopping, home maintenance (e.g., lawn care), booking appointments, getting to appointments, and asking questions during appointments. Informal caregiver burden is growing in Ontario. Organizations that provide paid support in the community can help to reduce informal caregiver burden; however, this cost of these services should not fall on patient or caregivers. Dimensions: Patient-Centered, Efficient, Effective, Safe, Timely Direction of Improvement: ↓
Additional Specifications	Calculation Methods: Numerator/Denominator*100 Survey of informal caregivers for patients Numerator: Number of informal caregivers of patients with multiple conditions and complex needs who received non-clinical support in the fourteen (14) day period post discharge and who express feelings of distress, anger or depression related to providing care to the patient Denominator: Number of informal caregivers of patients who have multiple conditions and complex needs that received non-clinical support in the fourteen (14) day period post discharge. Exclusions: Discharged patients with multiple conditions and complex needs who do not require non-clinical support in the community
Reporting Period	Recommend that Health Links collect and report data for a minimum of three (3) months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Comments	Selected outcome measures will help to evaluate the impact of the efforts to introduce innovative practices into transitions between hospital and home.

2. Percentage of patients with multiple conditions and complex needs who have paid or volunteer non-clinical assistance provided without charge to the patient in the immediate post discharge period up to fourteen (14) days

Stage of Hospital Stay	In the community post hospital stay
Innovative Practice	Designate a person in the community to support non clinical needs in the immediate post-hospital period
Type of Measure	Process Measure
Definition/Description	In the post hospital period, patients with multiple conditions and complex needs may need a support person to help support daily living activities such as grocery shopping, home maintenance (e.g., lawn care), booking appointments, getting to appointments, and asking questions during appointments. Informal caregiver burden is growing in Ontario. Organizations that provide paid support in the community can help to reduce informal caregiver burden; however, this cost of these services should not fall on patient or caregivers. Dimensions: Patient-Centered, Efficient, Effective, Safe, Timely Direction of Improvement: ↑
Additional Specifications	Calculation Methods: Numerator/Denominator*100 Survey of informal caregivers for patients Numerator: Percentage of patients with multiple conditions and complex needs who have paid or volunteer non-clinical assistance provided without charge to the patient in the immediate post discharge time in the fourteen (14) day period post discharge Denominator: Total number of patients who have multiple conditions and complex needs who have been hospitalized Exclusions: Discharged patients with multiple conditions and complex needs who do not require non-clinical support in the community
Reporting Period	Recommend that Health Links collect and report data for a minimum of three (3) months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Comments	The selected process measures are designed to help Health Links draw on the fields of Improvement Science and Implementation Science as these practices are implemented. Process Measures are used to assess: 1. Progress in implementation components such as reach (how often the practice is being used); 2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate; and 3. Sustainability of the process as designed so that it will continue once the initial attention has waned.

3. Satisfaction of patient who has multiple conditions and complex needs with the involvement of the support person(s) in the community

Stage of Hospital Stay	In the community post hospital stay
Innovative Practice	Designate a person in the community to support non clinical needs in the immediate post-hospital period
Type of Measure	Process Measure
Definition/Description	In the post hospital period, patients with multiple conditions and complex needs may need a support person to help support daily living activities such as grocery shopping, home maintenance (e.g., lawn care), booking appointments, getting to appointments, and asking questions during appointments. Informal caregiver burden is growing in Ontario. Organizations that provide paid support in the community can help to reduce informal caregiver burden; however, this cost of these services should not fall on patient or caregivers. Dimensions: Patient-Centered, Efficient, Effective, Safe, Timely Direction of Improvement: ↑
Additional Specifications	Calculation Methods: Numerator/Denominator*100 Survey of informal caregivers Numerator: Percentage of patients with multiple conditions and complex needs who have paid or volunteer non-clinical assistance provided without charge to the patient in the immediate post discharge time (in the 14 day period post discharge) who expressed a positive experience post discharge due to the involvement of the support person in the community Denominator: Number of patients who have multiple conditions and complex needs and received non-clinical support in the 14 day period post discharge Exclusions: Discharged patients multiple conditions and complex needs that do not require non-clinical support in the community
Reporting Period	Recommend that Health Links collect and report data for a minimum of three (3) months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Comments	The selected process measures are designed to help Health Links draw on the fields of Improvement Science and Implementation Science as these practices are implemented. Process Measures are used to assess: 1. Progress in implementation components such as reach (how often the practice is being used); 2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate; and 3. Sustainability of the process as designed so that it will continue once the initial attention has waned.