Transitions Between Hospital and Home

In the Community Post Hospital Stay: Follow-up with Patient within 48 hours of Transition Home

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*.

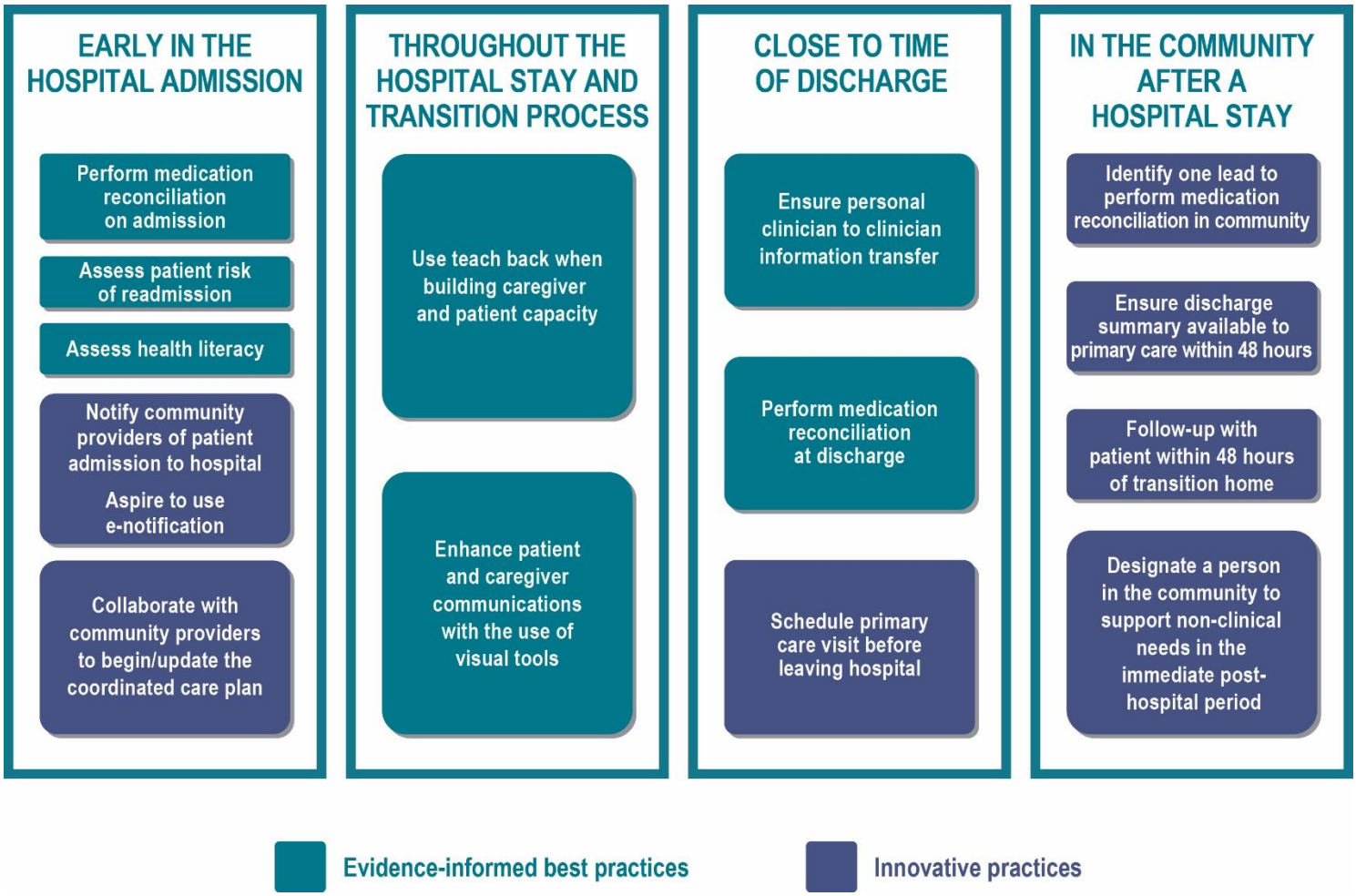

Figure 1: Practices to Improve Transitions Between Hospital and Home

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

Upon leaving the hospital, individuals identified as having a higher risk of readmission (through screening or clinical judgement) should be followed up with a phone call within 48 hours of discharge. The follow-up phone call within 48 hours of discharge should be made by a community provider and/or hospital care provider who is known to the patient, using a scripted or standardized approach with a focus on the following goals[1]:

- To monitor progress;
- To establish community networks for meeting patient needs;
- To enhance patient education and self-management training; and
- To provide follow up or reinforcement of the discharge plan/coordinated care plan.

Innovative Practice	Innovative Practice Assessment[2]	Clinical Reference Group Endorsement for Spread
Follow-up with patient within 48 hours of transition home.	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**
This practice includes two key elements: ***1. Provider with existing relationship place follow-up call within 48 hours of discharge*** The provider with an existing relationship (or who is the existing single point of contact) makes the follow-up phone call within 48 hours of discharge. ***2. Use a standard approach or script*** A standard approach or script should be used and would include the reinforcement of the discharge plan (and/or updated coordinated care plan) a review of the patient's health status, medications, appointments, community services and review what to do if problems arise.	• Prior to creating a standard work process for conducting a follow-up phone call, ensure the single point of contact has been identified. See **Coordinated Care Management Innovative Practices** (Invite and Engage the Patient at http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links/Coordinated-Care-Management/Invite-and-Engage-Patient Example scripts for the follow-up phone call: • **Project RED (Re-Engineered Discharge)** is a research group from Boston University Medical Centre that develops and tests strategies to improve the hospital discharge process. Component 12 of their process focuses providing telephone	• Consider patients' preferred method of communication (e.g., phone call, email, text). • Future exploration may be needed to determine if outcomes are impacted by the relationship between the caller and the patient (e.g., do outcomes differ if the caller is a physician, a provider in the patients' circle of care, or an automated message?) • If other services are planned to be in place (e.g., **Community Care Access Centre**) for follow-up post discharge within 48 hours, a follow-up phone call may create unnecessary duplication of services.

[1] Berkowitz R, Fang Z, Helfand B, Jones R, Schreiber R, Paasche-Orlow M. Project ReEngineered Discharge (RED) Lowers Hospital Readmissions of Patients Discharged From a Skilled Nursing Facility. Am Med Dir Assoc. 2013 Oct;14(10):736-40.

[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**
	reinforcement of the discharge plan (http://www.bu.edu/fammed/projectred/components.html). • **Mississauga Halton LHIN** – The **CCAC** developed the Seamless Transitions: Hospital to Home Guidebook (http://healthcareathome.ca/mh/en/Documents/SeamlessTransitionsGuidebook.pdf) and page 91 describes a telephone script that can be used for a follow-up phone call.	

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. Percentage of patients with multiple conditions and complex needs who visit the emergency department within seven (7) days post discharge 2. Percentage patients with multiple conditions and complex needs who experienced an unplanned readmission to hospital within 30 days of discharge.*	3. Time between discharge of patient and follow up phone call 4. Percentage of patients with multiple conditions and complex needs who identify new issues during the 48-hour follow-up phone call that were not previously identified at time of discharge 5. Percentage of patients satisfied with 48-hour post discharge follow up phone call	• 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 suggested measure is closely aligned to the indicator in Quality Improvement Plans (QIP).

References

1. Berkowitz R, Fang Z, Helfand B, Jones R, Schreiber R, Paasche-Orlow M. Project ReEngineered Discharge (RED) Lowers Hospital Readmissions of Patients Discharged From a Skilled Nursing Facility. Am Med Dir Assoc. 2013 Oct;14(10):736-40.

2. Mistiaen P, Poot E. Telephone Follow-up Initiated by a Hospital Based Health Professional for Post Discharge Problems in Patients Discharged from Hospital to Home. Cochrane Database Syst Revew. 2006 Oct 18;(4):CD004510.

3. Record JD, Niranjan-Azadi A, Christmas C, Hanyok LA, Rand CS, Hellmann DB, Ziegelstein RC. Telephone Calls to Patients After Discharge from the Hospital: An Important Part of Transitions of Care. Med Educ Online. 2015;20:26701. Available from: http://www.med-ed-online.net/index.php/meo/article/view/26701

4. Tang N, Fujimoto J, Karliner L. Evaluation of a Primary Care-Based Post-Discharge Phone Call Program: Keeping the Primary Care Practice at the Center of Post-Hospitalization Care Transition. J Gen Intern Med. 2014 Nov;29(11):1513-1518.

Appendix A:
Measurement Specifications for Following-up with Patient within 48 hours of Transition Home

Released September 2016

1. Percentage of patients with multiple conditions and complex needs who visit the emergency department within seven (7) days post discharge

Stage of Hospital Stay	In the community post hospital stay
Innovative Practice	Follow-up with patient within 48 hours of transition home
Type of Measure	Outcome Measure
Definition/Description	Upon leaving the hospital, individuals identified as having a higher risk of readmission (through screening or clinical judgement) should be followed up with a phone call with 48 hours of discharge. The follow-up phone call within 48 hours of discharge should be made by a community provider and/or hospital care provider who is known to the patient, using a scripted or standardized approach with the focus on the following goals: • To monitor progress; • To establish community networks for meeting patient needs; • To enhance patient education and self-management training; and • To provide follow up or reinforcement of the discharge plan/coordinated care plan. Dimensions: Effective, Patient Centered, Safe, Timely Direction of Improvement: ↓
Additional Specifications	Calculation Methods: Numerator/ Denominator*100 Numerator: Number of patients with multiple conditions and complex needs who were recently discharged from hospital within seven (7) days and had an unplanned visit to the emergency department Denominator: Number of patients with multiple conditions and complex needs who were recently discharged from hospital within seven (7) days Exclusion Criteria: Patients with multiple conditions and complex needs who visit the ED within seven (7) days of discharge for reasons unrelated to original admission to hospital. Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, have died, transferred to a different facility or signed out
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 patients with multiple conditions and complex needs who experienced an unplanned readmission to hospital within 30 days of discharge

Stage of Hospital Stay	In the community post hospital stay
Innovative Practice	Follow-up with patient within 48 hours of transition home
Type of Measure	Outcome Measure
Definition/Description	Upon leaving the hospital, individuals identified as having a higher risk of readmission (through screening or clinical judgement) should be followed up with a phone call with 48 hours of discharge. The follow-up phone call within 48 hours of discharge should be made by a community provider and/or hospital care provider who is known to the patient, using a scripted or standardized approach with the focus on the following goals: • To monitor progress; • To establish community networks for meeting patient needs; • To enhance patient education and self-management training; and • To provide follow up or reinforcement of the discharge plan/coordinated care plan. Dimensions: Effective, Patient Centered, Safe, Timely Direction of Improvement: ↓
Additional Specifications	Calculation Method: Numerator/Denominator*100 Numerator: Number of patients who have multiple conditions and complex needs who have an unplanned readmission to hospital within 30 days of discharge Denominator: Total number of patients who have multiple conditions and complex needs who are discharged from hospital Exclusion Criteria: Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, have died, transferred to a different facility or signed out
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.

3. Time between discharge of patient and follow up phone call

Stage of Hospital Stay	In the community post hospital stay
Innovative Practice	Follow-up with patient within 48 hours of transition home
Type of Measure	Process Measure
Definition/Description	Upon leaving the hospital, individuals identified as having a higher risk of readmission (through screening or clinical judgement) should be followed up with a phone call with 48 hours of discharge. The follow-up phone call within 48 hours of discharge should be made by a community provider and/or hospital care provider who is known to the patient, using a scripted or standardized approach with the focus on the following goals: • To monitor progress; • To establish community networks for meeting patient needs; • To enhance patient education and self-management training; and • To provide follow up or reinforcement of the discharge plan/coordinated care plan. Dimensions: Effective, Patient Centered, Safe, Timely Direction of Improvement: ↓
Additional Specifications	Calculation Method: Average or median time per week **Time:** The number of hours (rounded to the nearest half hour) between the time of discharge and the time of follow-up (phone call) Average: The total **time** recorded during the week/The total frequency that the **time** was recorded during the week Median: In a sorted list of the **times** per week, the median is the middle number Exclusion Criteria: Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, have died, transferred to a different facility or signed out
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.

4. Percentage of patients with multiple conditions and complex needs who identify new issues during the 48-hour follow-up phone call that were not previously identified at time of discharge

Stage of Hospital Stay	In the community post hospital stay
Innovative Practice	Follow-up with patient within 48 hours of transition home
Type of Measure	Process Measure
Definition/Description	Upon leaving the hospital, individuals identified as having a higher risk of readmission (through screening or clinical judgement) should be followed up with a phone call with 48 hours of discharge. The follow-up phone call within 48 hours of discharge should be made by a community provider and/or hospital care provider who is known to the patient, using a scripted or standardized approach with the focus on the following goals: • To monitor progress; • To establish community networks for meeting patient needs; • To enhance patient education and self-management training; and • To provide follow up or reinforcement of the discharge plan/coordinated care plan. Dimensions: Effective, Patient Centered, Safe, Timely Direction of Improvement: ↓
Additional Specifications	Calculation Method: Numerator/Denominator*100 Numerator: Number of patients with multiple conditions and complex needs who identify one or more new issue(s) during the follow-up phone call Denominator: Total number of patients with multiple conditions and complex needs that receive a follow-up phone call with 48 hours of discharge List of issues: Issues log recorded and reviewed weekly for identification of themes and opportunities for improvement
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; 3. Sustainability of the process as designed so that it will continue once the initial attention has waned.

5. Percentage of patients satisfied with 48-hour post discharge follow up phone call

Stage of Hospital Stay	In the community post hospital stay
Innovative Practice	Follow-up with patient within 48 hours of transition home
Type of Measure	Process Measure
Definition/ Description	Upon leaving the hospital, individuals identified as having a higher risk of readmission (through screening or clinical judgement) should be followed up with a phone call with 48 hours of discharge. The follow-up phone call within 48 hours of discharge should be made by a community provider and/or hospital care provider who is known to the patient, using a scripted or standardized approach with the focus on the following goals: • To monitor progress; • To establish community networks for meeting patient needs; • To enhance patient education and self-management training; and • To provide follow up or reinforcement of the discharge plan/coordinated care plan. Dimensions: Effective, Patient Centered, Safe, Timely Direction of Improvement: ↓
Additional Specifications	Calculation Method: Numerator/Denominator*100 Numerator: Number of patients with multiple conditions and complex needs who report that they "Agree" or "Strongly agree" with the statement *"I am satisfied with follow-up phone call that I received within 48 hours of discharge"* Denominator: Number of patients surveyed Exclusion Criteria: Patients that did not receive a follow-up phone call within 48 hours
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; 3. Sustainability of the process as designed so that it will continue once the initial attention has waned.