Transitions Between Hospital and Home

In The Community After a Hospital Stay: Identify One Lead to Perform Medication Reconciliation in the Community

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*.

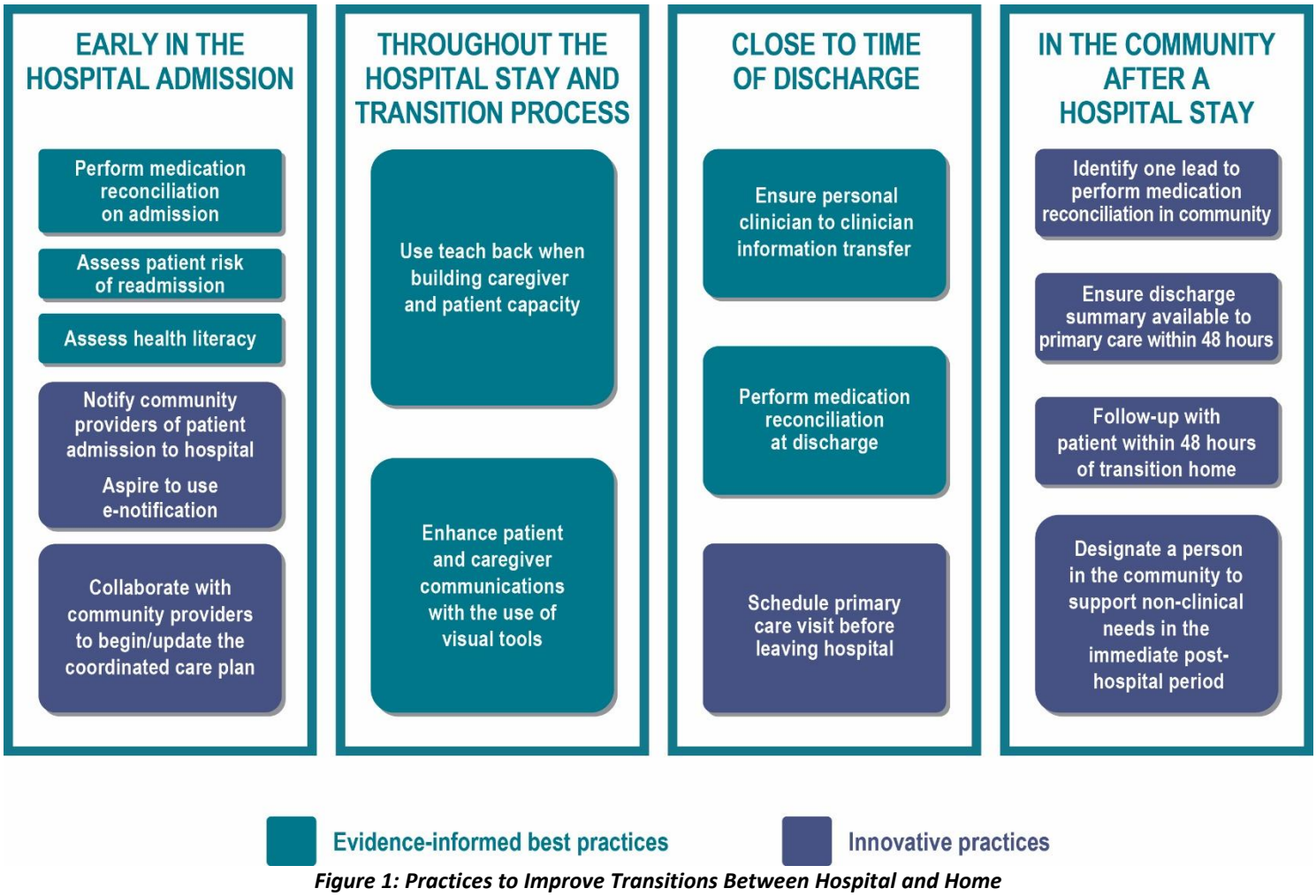

Figure 1: Practices to Improve Transitions Between Hospital and Home

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

To reduce medication errors and duplicated effort, one lead for performing medication reconciliation in the community should be identified and connected with both the care team and the patient prior to discharge. The lead performing medication reconciliation may or may not be the same individual as the single point of contact. The results of the medication reconciliation should then be documented and shared with the patient's circle of care. This may be done through the single point of contact and the coordinated care plan.

Innovative Practice	Innovative Practice Assessment[1]	Clinical Reference Group Endorsement for Spread
Identify one lead to perform medication reconciliation in the community.	PROMISING	Provincial spread with reassessment using the Innovative Practices Evaluation Framework[1] in one year (September 2017).

Implementation of the Innovative Practice

Steps for Implementation	Tools and Resources	Considerations
1. Select medication reconciliation lead The single point of contact and the patient select one lead for medication reconciliation based upon the plan of care post discharge. ***2. Medication reconciliation lead commits*** The identified medication reconciliation lead understands their role and commits to a medication management process for the patient. ***3. Perform medication reconciliation and update Coordinated Care Plan (CCP)*** The medication reconciliation lead coordinates and documents medication reconciliation for the patient upon admission and discharge. The coordinated care plan (CCP) is updated to reflect the medication reconciliation on discharge (For more information about best practices for medication reconciliation, please refer to Evidence Informed Best Practice documents called **Perform Medication Reconciliation at Admission** and **Perform Medication Reconciliation at Discharge**. ***4. Share CCP with care team*** The CCP is shared with the care team upon discharge to communicate accurate medication records.	Examples from the Field: • **South East LHIN: Kingston Rural Health Link** – The CCAC Rapid Response Nurse leads community medication reconciliation. • **Central LHIN**: **The CCAC** pharmacists visit patients in their home to review all the medications they are taking and gather information to determine if there are any drug interactions and side effects. The pharmacists discuss "high alert" medications that need to be monitored closely. After developing a medication plan, and with the patient's permission, the pharmacist reviews it with the primary care provider/specialist and their other health care providers to arrange for any necessary follow-up services. This service is performed by a rapid response nurse within 24 to 48 hours of release for patients who are discharged from hospital.	• The main issue is to reduce the redundancy and frustration for the patient when multiple medication reconciliations occur post hospital discharge. Consider evaluating the impact of the collaboration on the number of medication reconciliations for this transition of care (i.e., has the collaboration reduced redundancy?)

[1] *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*

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 medication errors for patients with multiple conditions and complex needs that lead to an emergency department visit 2. Number of medication discrepancies for patients with multiple conditions and complex needs (error did not reach the patient)	3. Percentage of patients with multiple conditions and complex needs for whom one lead is identified for medication reconciliation 4. Number of medication reconciliations completed per patient with multiple conditions and complex needs in the community post discharge 5. Staff satisfaction related to medication reconciliation process	• 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.

References

1. Jackson C, Shahsahebi M, Wedlake T, DuBard CA. Timelines of Outpatient Follow-up: An Evidence Based Approach for Planning After Hospital Discharge. Ann Fam Med. 2015 Mar/Apr;13(2):115-122. Available from: http://www.annfammed.org/content/13/2/115.full.pdf+html
2. Facilitating Medication Safety at Transitions: A Toolkit and Checklist for Healthcare Providers. Institute for Safe Medication Practices; 2015 [cited 2016 May]. Available from: http://ismp-canada.instorg/transitions/
3. Kwan JL, Lo L, Sampson M, Shojania KG. Medication Reconcilitation During Transitions of Care as a Patient Safety Strategy: a Systematic Review. Ann Intern Med. 2013;158(5 Pt 2):397-403.
4. Pevnick JM, Shane R, Schnipper JL. The Problem with Medication Reconciliation. BMJ Qual Saf. 2016 Jan 21. doi: 10.1136/bmjqs-2015-004734. [Epub ahead of print].
5. Warden BA, Freels JP, Furuno JP, Mackay J. Pharmacy-Managed Program for Providing Education and Discharge Instructions for Patients with Heart Failure. Am J Health Syst Pharm. 2014;71(2):134-9.

Appendix A:
Measurement Specifications for Identifying One Lead to Perform Medication Reconciliation in the Community

Released September 2016

1. Percentage of medication errors for patients with multiple conditions and complex needs that lead to an emergency department visit

Stage of Hospital Stay	In the community after a hospital stay
Innovative Practice	Identify one lead to perform medication reconciliation in the community.
Type of Measure	Outcome Measure
Definition/Description	The single point of contact and the patient selects one lead for medication reconciliation based upon the plan of care post discharge. The identified medication reconciliation lead understands their role and commits to a medication management process for the patient. The medication reconciliation lead coordinates and documents medication reconciliation for the patient upon admission and discharge. The coordinated care plan (CCP) is updated to reflect the medication reconciliation on discharge. The CCP is shared with the care team upon discharge to communicate accurate medication records. Dimensions: Effective, Efficient, Patient-Centered, Safe Direction of Improvement: ↓
Additional Specifications	Calculation Methods: Numerator/Denominator*100 Numerator: Number of patients with multiple conditions and complex needs that were recently discharged from hospital (within 30 days) and visited the emergency department for reasons related to medication error(s) Denominator: Number of patients with multiple conditions and complex needs who were recently discharged from hospital (within 30 days) Exclusion Criteria: Patients with multiple conditions and complex needs who visit the emergency department within 30 days of discharge for reasons unrelated to medication error(s)
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. Number of medication discrepancies for patients with multiple conditions and complex needs (error did not reach the patient)

Stage of Hospital Stay	In the community after a hospital stay
Innovative Practice	Identify one lead to perform medication reconciliation in the community.
Type of Measure	Outcome Measure
Definition/Description	The single point of contact and the patient selects one lead for medication reconciliation based upon the plan of care post discharge. The identified medication reconciliation lead understands their role and commits to a medication management process for the patient. The medication reconciliation lead coordinates and documents medication reconciliation for the patient upon admission and discharge. The coordinated care plan (CCP) is updated to reflect the medication reconciliation on discharge. The CCP is shared with the care team upon discharge to communicate accurate medication records. Dimensions: Effective, Patient Centered, Safe, Timely Direction of Improvement: ↓
Additional Specifications	The following audit and feedback cycle should be implemented to compare what is actually done against a reference standard: 1. Plan the audit by identifying the problem, the objectives, the participants, responsibilities, timelines and resources. 2. Define the standards of best practice against which performance will be compared. 3. Gather evidence of performance. 4. Compare the results with standards. 5. Identify gaps and provide feedback for solutions / action steps. 6. Close the loop by monitoring the results. <u>Exclusion Criteria:</u> 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 complete an audit cycle weekly or monthly. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection and periodic audit of available staff on that day.
Comments	Selected outcome measures will help to evaluate the impact of the efforts to introduce innovative practices into transitions between hospital and home.

3. Percentage of patients with multiple conditions and complex needs for whom one lead is identified for medication reconciliation

Stage of Hospital Stay	In the community after a hospital stay
Innovative Practice	Identify one lead to perform medication reconciliation in the community.
Type of Measure	Process Measure
Definition/Description	The single point of contact and the patient selects one lead for medication reconciliation based upon the plan of care post discharge. The identified medication reconciliation lead understands their role and commits to a medication management process for the patient. The medication reconciliation lead coordinates and documents medication reconciliation for the patient upon admission and discharge. The coordinated care plan (CCP) is updated to reflect the medication reconciliation on discharge. The CCP is shared with the care team upon discharge to communicate accurate medication records. 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 for whom one lead is identified by the patient for medication reconciliation Denominator: Number of patients with multiple conditions and complex needs 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. Number of medication reconciliations completed per patient with multiple conditions and complex needs in the community post discharge

Stage of Hospital Stay	In the community after a hospital stay
Innovative Practice	Identify one lead to perform medication reconciliation in the community.
Type of Measure	Process Measure
Definition/Description	The single point of contact and the patient selects one lead for medication reconciliation based upon the plan of care post discharge. The identified medication reconciliation lead understands their role and commits to a medication management process for the patient. The medication reconciliation lead coordinates and documents medication reconciliation for the patient upon admission and discharge. The coordinated care plan (CCP) is updated to reflect the medication reconciliation on discharge. The CCP is shared with the care team upon discharge to communicate accurate medication records. Dimensions: Effective, Patient Centered, Safe, Timely Direction of Improvement: ↓
Additional Specifications	The following audit and feedback cycle should be implemented to compare what is actually done against a reference standard: 1. Plan the audit by identifying the problem, the objectives, the participants, responsibilities, timelines and resources. 2. Define the standards of best practice against which performance will be compared. 3. Gather evidence of performance. 4. Compare the results with standards. 5. Identify gaps and provide feedback for solutions / action steps. 6. Close the loop by monitoring the results. <u>Exclusion Criteria:</u> 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 complete an audit cycle weekly or monthly. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection and periodic audit of available staff on that day.
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5. Staff satisfaction related to medication reconciliation process

Stage of Hospital Stay	In the community after a hospital stay
Innovative Practice	Identify one lead to perform medication reconciliation in the community.
Type of Measure	Process Measure
Definition/ Description	The single point of contact and the patient selects one lead for medication reconciliation based upon the plan of care post discharge. The identified medication reconciliation lead understands their role and commits to a medication management process for the patient. The medication reconciliation lead coordinates and documents medication reconciliation for the patient upon admission and discharge. The coordinated care plan (CCP) is updated to reflect the medication reconciliation on discharge. The CCP is shared with the care team upon discharge to communicate accurate medication records. Dimensions: Effective, Patient Centered, Safe, Timely Direction of Improvement: ↑
Additional Specifications	Calculation Method: Numerator/Denominator*100 Numerator: Number of staff who report that they "Agree" or "Strongly agree" with the statement *"I am satisfied with our current medication reconciliation process"* Denominator: Number of staff surveyed Exclusion Criteria: Staff who are not involved in the medication reconciliation process
Reporting Period	Recommend that Health Links complete an audit cycle weekly or monthly. 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.