Transitions Between Hospital and Home

Early in the Hospital Admission: Notify Community Providers of Patient Admission to Hospital Aspire to Use e-Notification

Released September 2016

Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, specialists 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*.

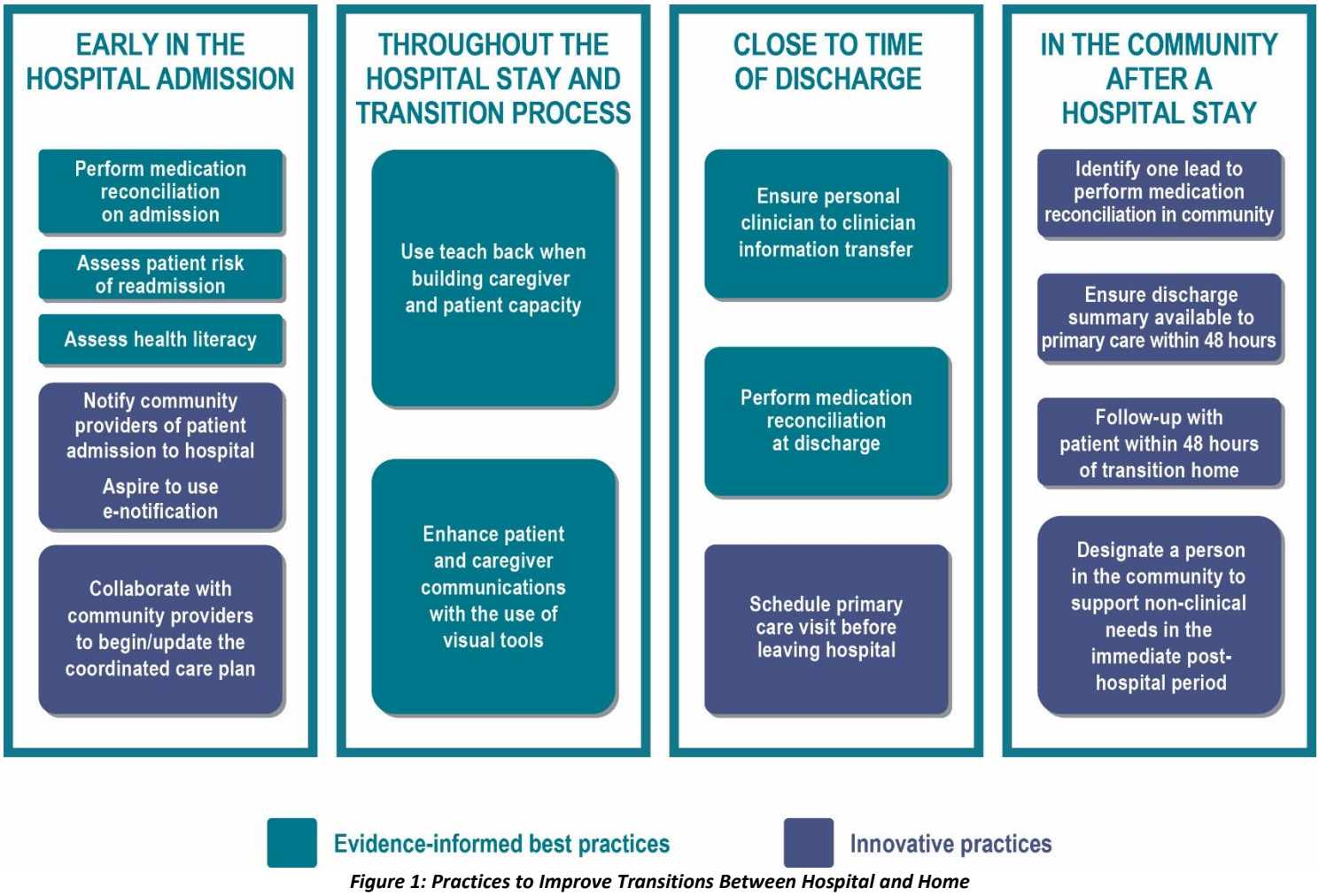

Figure 1: Practices to Improve Transitions Between Hospital and Home

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

The need for timely communication among care providers is well established in the literature. Interdisciplinary collaboration and communication support positive patient outcomes. Involving the circle of care early in the process allows more time to develop post-hospital treatment plans and helps patients and caregivers prepare for the shift from hospital to home, and involves:

a) Timely notification of a patient's hospital admission to the patient's community health care team provides them with an opportunity to make informed decisions about appropriate follow-up care based on the latest information. There are many ways that community providers can be contacted or notified. Recognizing that Health Links and the partner organizations vary, LHINs and Health Links are encouraged to adapt a system or process that meets their local context and population's needs.

b) E-notification is a real-time (or near real-time) electronic-message that notifies providers when their patients are discharged from the Emergency Department, or are admitted/discharged from in-patient units. E-notifications provide early access to the latest information about patients, and support the recommended guideline of patient follow-up within seven days post-discharge.

Innovative Practice	Innovative Practice Assessment[1]	Clinical Reference Group Endorsement for Spread
a) Notify community providers of patient admission to hospital b) Aspire to use e-Notification	PROMISING	a) Provincial spread with reassessment using the Innovative Practices Evaluation Framework[1] in one year (Sept 2017). b) Targeted spread with specific contexts (where e-notification is available or feasible)

Implementation of the Innovative Practice		
Steps for Implementation	**Tools and Resources**	**Considerations**
1. Identify the patient Health Link care team identifies that a patient with multiple conditions and complex needs is transitioning to hospital (possibly in the ED or upon inpatient admission). ***2. Identify the circle of care*** The patient (or delegate) and the single point of contact identify the patient's existing circle of care members to be notified of the admission, including family physician/Nurse Practitioner, community care/service providers. ***3. Notify providers*** Once the circle of care members are identified, begin notifying them of the patient's admission.	Refer to the **Coordinated Care Management Innovative Practices** "Decision Support Tool" to identify new or existing Health Links patients (http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links/Coordinated-Care-Management/Identify-Patient). Example Health Links known to use e-notifications are: 1. **Toronto Central (TC) LHIN: Mid-West Health Link** and **University Health Network (UHN)** with **Toronto Community Addiction Team (TCAT)**	• E-notification methods may be dependent on organizations/providers' abilities to build on existing processes, partnerships and technologies. • E-notification systems may have their own onboarding phases planned, with Health Service Providers wait listed to receive access to the technology solution. • During the implementation of this innovation: ○ Consider using a single consent process and/or form (see **Coordinated Care Management Innovative Practice** for Single Consent:

[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*

Implementation of the Innovative Practice		
Steps for Implementation	**Tools and Resources**	**Considerations**
4. E-notification Several Health Links use e-notification with specific populations (e.g., mental health) or with specific sectors (e.g., primary care), while others use a broader population and/or sector approach.	2. **TC LHIN: Toronto East General Hospital** with **South East Toronto Family Health Team (East Toronto Health Link)** using **Ontario MD**, Hospital Report Manager (https://www.ontariomd.ca/portal/server.pt/community/hospital_report_manager/710/enotifications/23598). 3. **TC LHIN: Don Valley Greenwood Health Link** with **Toronto Paramedics Services Community Agency Notification (CAN)** program	http://www.hqontario.ca/Portals/0/documents/qi/health-links/ccm-invite-and-engage-consent-en.pdf); and ○ Review policies and procedures related to use of personal health information and the Personal Health Information Protection Act (PHIPA). • Refer to information and resources related to patient identification, single point of contact, and single consent processes outlined in **Coordinated Care Management Innovative Practices:** http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links/Coordinated-Care-Management Enablers include: • Data sharing agreements • Technology capable of delivering e-notifications

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 experienced an unplanned readmission to hospital within thirty (30) days of discharge.*	2. Percentage of patient admission notifications or e-notifications sent to primary care providers (PCP). 3. Percentage of patients with multiple conditions and complex needs identified as needing connection to local Health Link on admission to hospital and offered this connection.	• 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. Accreditation Canada [Internet]. Community Agency Notification Program. [Place unknown]: Accreditation Canada; c2013 [cited 2016 May]. Available from: https://accreditation.ca/community-agency-notification-program.

2. Giosa JL, Stolee P, Dupuis SL, Mock SE, Santi SM. An Examination of Family Caregiver Experiences During Care Transitions of Older Adults. Can J Aging. 2014;33(2):137-153.

3. Lancaster G, Kolakowsky-Hayner S, Kovacich J, Greer-Williams N. Interdisciplinary Communication and Collaboration Among Physicians, Nurses, and Unlicensed Assistive Personnel. J Nurs Scholarsh. 2015;47(3): 275-284.

4. OntarioMD [Internet]. About eNotifications. [Place unknown]: OntarioMD; [cited 2016 May]. Available from: https://www.ontariomd.ca/portal/server.pt/community/hospital_report_manager/710/enotifications/23598

Appendix A:
Measurement Specifications for
Notify Community Providers of Patient Admission to Hospital
Aspire to use e-Notification

Released September 2016

1. Percentage of patients with multiple conditions and complex needs who experienced an unplanned readmission to hospital within thirty (30) days of discharge

Stage of Hospital Stay	Early in the hospital admission
Innovative Practice	a) Notify community providers of patient admission to hospital b) Aspire to use e-notification
Type of Measure	Outcome Measure
Definition/Description	a) Timely notification of a patient's hospital admission to the patient's community health care team provides them with an opportunity to make informed decisions about appropriate follow-up care based on the latest information. There are many ways that community providers can be contacted or notified. Recognizing that Health Links and the partner organizations vary, LHINs and Health Links are encouraged to adapt a system or process that meets their local context and population's needs. b) E-notification is a real-time (or near real-time) electronic-message that notifies providers when their patients are discharged from the Emergency Department, or are admitted/discharged from in-patient units. E-notifications provide early access to the latest information about patients, and support the recommended guideline of patient follow-up within seven days post-discharge. Dimensions: Effective, Efficient, Patient-Centered, Safe Direction of Improvement: ↓
Additional Specifications	Calculation Method: Numerator/Denominator*100 Numerator: Number of patients who have multiple conditions and complex needs who are readmitted to an acute care hospital within thirty (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.

2. Percentage of patient admission notifications or e-notifications sent to primary care providers (PCP)

Stage of Hospital Stay	Early in the hospital admission
Innovative Practice	a) Notify community providers of patient admission to hospital b) Aspire to use e-notification
Type of Measure	Process Measure
Definition/Description	a) Timely notification of a patient's hospital admission to the patient's community health care team provides them with an opportunity to make informed decisions about appropriate follow-up care based on the latest information. There are many ways that community providers can be contacted or notified. Recognizing that Health Links and the partner organizations vary, LHINs and Health Links are encouraged to adapt a system or process that meets their local context and population's needs. b) E-notification is a real-time (or near real-time) electronic-message that notifies providers when their patients are discharged from the Emergency Department, or are admitted/discharged from in-patient units. E-notifications provide early access to the latest information about patients, and support the recommended guideline of patient follow-up within seven days post-discharge. Dimensions: Effective, Efficient, Patient-Centered, Safe Direction of Improvement: ↑
Additional Specifications	Calculation Methods: Numerator/Denominator*100 Numerator: Number of patients admitted to hospital who have multiple conditions and complex needs, that have a notification sent to their primary care provider (MD or NP) notifying them of the admission to hospital Denominator: Total number of patients admitted to hospital who have 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.

3. Percentage of patients with multiple conditions and complex needs identified as needing connection to local Health Link on admission to hospital and offered this connection

Stage of Hospital Stay	Early in the hospital admission
Innovative Practice	a) Notify community providers of patient admission to hospital b) Aspire to use e-notification
Type of Measure	Process Measure
Definition/Description	a) Timely notification of a patient's hospital admission to the patient's community health care team provides them with an opportunity to make informed decisions about appropriate follow-up care based on the latest information. There are many ways that community providers can be contacted or notified. Recognizing that Health Links and the partner organizations vary, LHINs and Health Links are encouraged to adapt a system or process that meets their local context and population's needs. b) E-notification is a real-time (or near real-time) electronic-message that notifies providers when their patients are discharged from the Emergency Department, or are admitted/discharged from in-patient units. E-notifications provide early access to the latest information about patients, and support the recommended guideline of patient follow-up within seven days post-discharge. Dimensions: Effective, Efficient, Patient-Centered, Safe Direction of Improvement: ↑
Additional Specifications	Calculation Method: Numerator/Denominator*100 Numerator: Number of patients with multiple conditions and complex needs identified and offered connection to the Health Link Denominator: Total number of patients with multiple conditions and complex needs admitted to the 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	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.