Transitions Between Hospital and Home

Close to Time of Discharge: Schedule a Primary Care Visit Before Leaving Hospital

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 finally *emerging practices*.

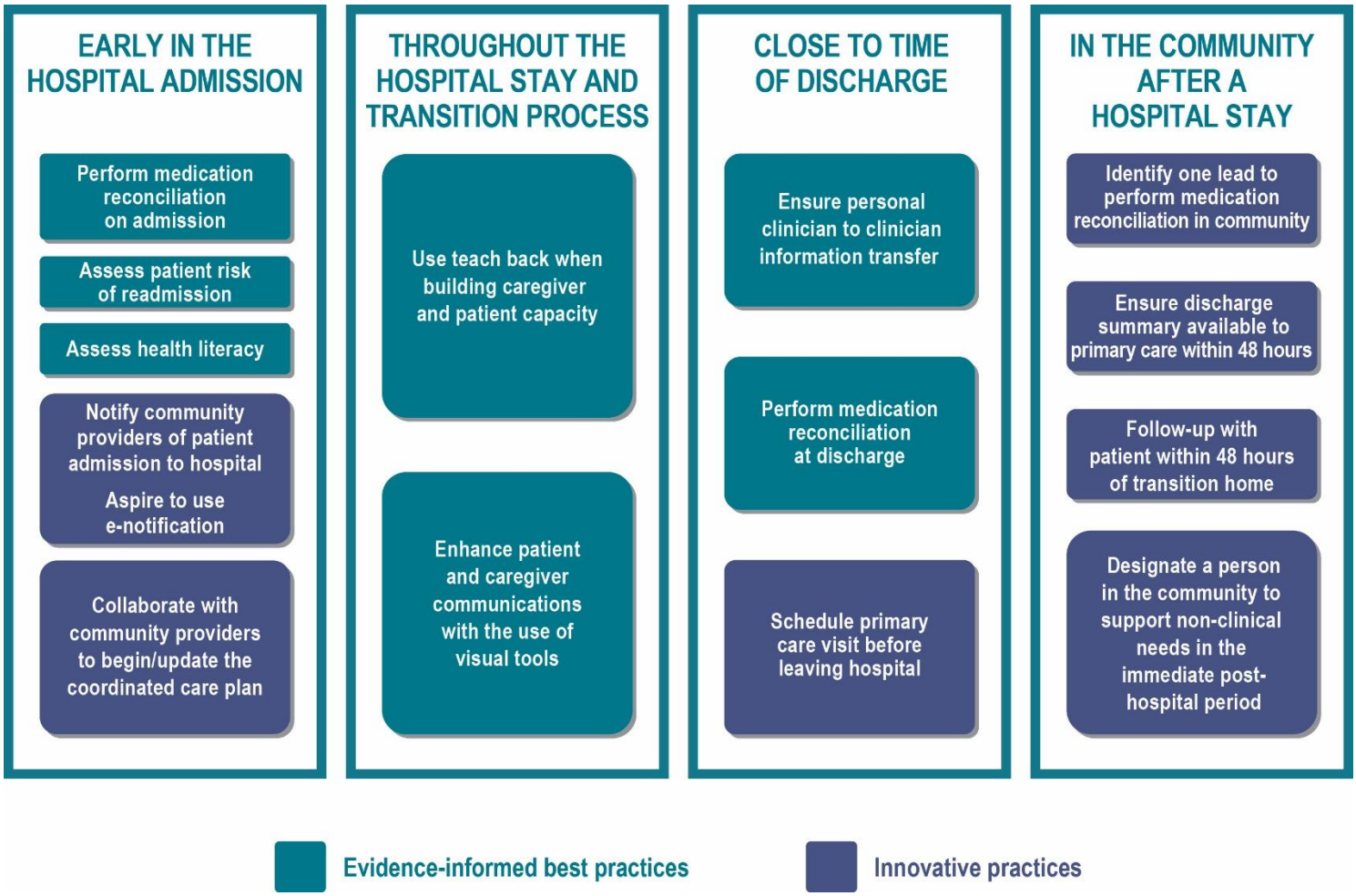


Figure 1: Practices to Improve Transitions Between Hospital and Home

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

Ensuring that patients with multiple conditions and complex needs have a primary care provider visit pre-booked to take place within seven (7) days post hospital discharge is a key enabler of a smooth transition. Therefore, before a patient is discharged from hospital, their appointment should be scheduled and confirmed with the patient, thus improving communication and timely access to care.

This innovation is closely tied to a second innovative practice, whereby hospitals ensure that their primary care provider is aware and able to access the discharge summary within 48 hours. It is recommended that both the pre-booking of a follow-up appointment within seven days and the completion of the discharge summary within 48 hours be implemented together. As Flink and his team describe in a 2015 publication, *"discharge information sent to primary healthcare cannot be considered as a means of securing continuity of patient care. Healthcare providers need to be aware that neither their discharge notes nor their referrals will guarantee continuity of patient care."*[1]

Innovative Practice	Innovative Practice Assessment[2]	Clinical Reference Group Endorsement for Spread
Schedule primary care visit before leaving hospital.	PROMISING	Provincial spread with reassessment using the Innovative Practices Evaluation Framework[2] in 1 year (Sept 2017). ❖ This should be implemented in conjunction with the innovative practice to have a discharge summary available within 48 hours.

Implementation of the Innovative Practice		
Steps for Implementation	**Tools and Resources**	**Considerations**
1. Obtain estimated date of discharge Work with the interprofessional team of clinicians to develop the patient's plan of care such that he/she can continue care at home. As the patient progresses, estimate the date of discharge and communicate the date with the care team, primary care provider and patient/caregiver. ***2. Consult with patient for booking preference*** Consult with the patient prior to scheduling a follow-up appointment since exceptions may occur, including situations where patients have post hospital plans (e.g., recovering at a friend's home in another city or wanting to wait until an informal caregiver is off work and able to join in the primary care appointment). ***3. Identify and mitigate barriers that would prevent the patient from attending the appointment*** In discussion with the patient about the appointment, identify potential challenges that might prevent him/her	Some examples and options for standard work processes to pre-book appointments may include: • Identify a specific person at the hospital to connect with the primary care practice (PCP) to book and confirm appointment. ○ Example from the Field: **St. Thomas Elgin General Hospital** engages the ward clerk position to pre-book primary care follow-ups (see **Appendix A** for sample standard operating procedure) • Engage the primary care provider office to pre-book the appointment while patient is in hospital.	• Prior to creating a standard work process for pre-booking appointments, ensure the single consent form has been implemented. See **Coordinated Care Management Innovative Practices** on Invite and Engage the Patient: http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links/Coordinated-

[1] Flink M, Bergenbrant GS, Airosa F, Öhlén G, Barach P, Hansaqi H, Brommels M, Olsen M. Patient-Centred Handovers Between Hospital and Primary Health Care: An Assessment of Medical Records. Int J Med Inform. 2015 May;84(5):355-62.

[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**
from attending the appointment (e.g., lack of transportation to the appointment or lack of a support caregiver also available to attend). ***4. Book follow-up appointment with primary care to occur within seven days of discharge*** There are many potential standardized processes for booking appointments with primary care depending on the practice type. This process will require a collaborative approach between hospital and primary care. ***5. Confirm follow-up appointment with patient*** Ensure the patient has copy of their appointment date, time, and location in their information package to go home. (Some organizations provide a fridge magnet to write appointments on or also send a follow-up email reminder.) ***6. Document appointment in both the discharge plan and the Coordinated Care Plan*** Document the date, time, and location of the follow-up appointment in both the discharge plan and the Coordinated Care Plan to ensure the entire care team is are of post charge plans and to help ensure that the patient attends scheduled appointments. ***7. Ensure the primary care provider receives the discharge summary within 48 hours*** It is recommended that both practices of pre-booking appointments to take place within seven days post discharge and ensuring the discharge summary is available within 48 hours be implemented together to ensure optimum information exchange.	(see **Coordinated Care Management Innovative Practices on Update and Action Care Plan)**: http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links/Coordinated-Care-Management/Update-and-Action-Care-Plan ○ Example from the Field: **Peterborough Health Link & Family Health Team (FHT)** maintains contact with the patient throughout hospital stay and the FHT staff own the process of pre-booking the primary care appointment and sharing with the patient and hospital staff. ○ **Hamilton Niagara Haldimand Brant LHIN** sends a discharge alert to primary care teams that requests a follow-up appointment for the patient as part of a Transitions Bundle (**see Appendix B**) • Establish a completely electronic process for booking PCP appointment from the hospital (including confirmation of appointment). • **Machealth** E-Learning modules are available to those interested in learning more about the principles of Advanced Access and Efficiency. **Machealth** E-Learning modules are available from: http://machealth.ca/programs/advanced-access-efficiency-primary-care/	Care-Management/Invite-and-Engage-Patient • Developing a practice of pre-booking appointments requires collaboration between hospital and local primary care providers. • It is important to recognize that more than one booking process may be required to meet patient or primary care provider needs.

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 C for additional details)

Suggested Outcome Measures	Suggested Process Measures	Additional Information
1. Percentage of patients who have multiple conditions and complex needs who see their primary care provider within seven days (7) after discharge from hospital* 2. Percentage of patients with multiple conditions and complex needs who experienced an unplanned readmission to hospital within thirty (30) days of discharge*	3. Percentage of patients with multiple conditions and complex needs who have a primary care provider appointment that was **pre-booked** prior to leaving the hospital 4. Percentage of patients with multiple conditions and complex needs **identified as no-shows** to their follow-up appointment with their primary care provider appointment that was pre-booked to occur within seven (7) days post hospital discharge 5. Percentage of patients with multiple conditions and complex needs who are **unable to have an appointment pre-booked** within seven (7) days post discharge due to primary care availability 6. Percentage of patients with multiple conditions and complex needs who **decline** an offer for an appointment within seven (7) days of discharge 7. Average number of days to primary care follow-up appointment for patients who have multiple conditions and complex needs post discharge	• 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

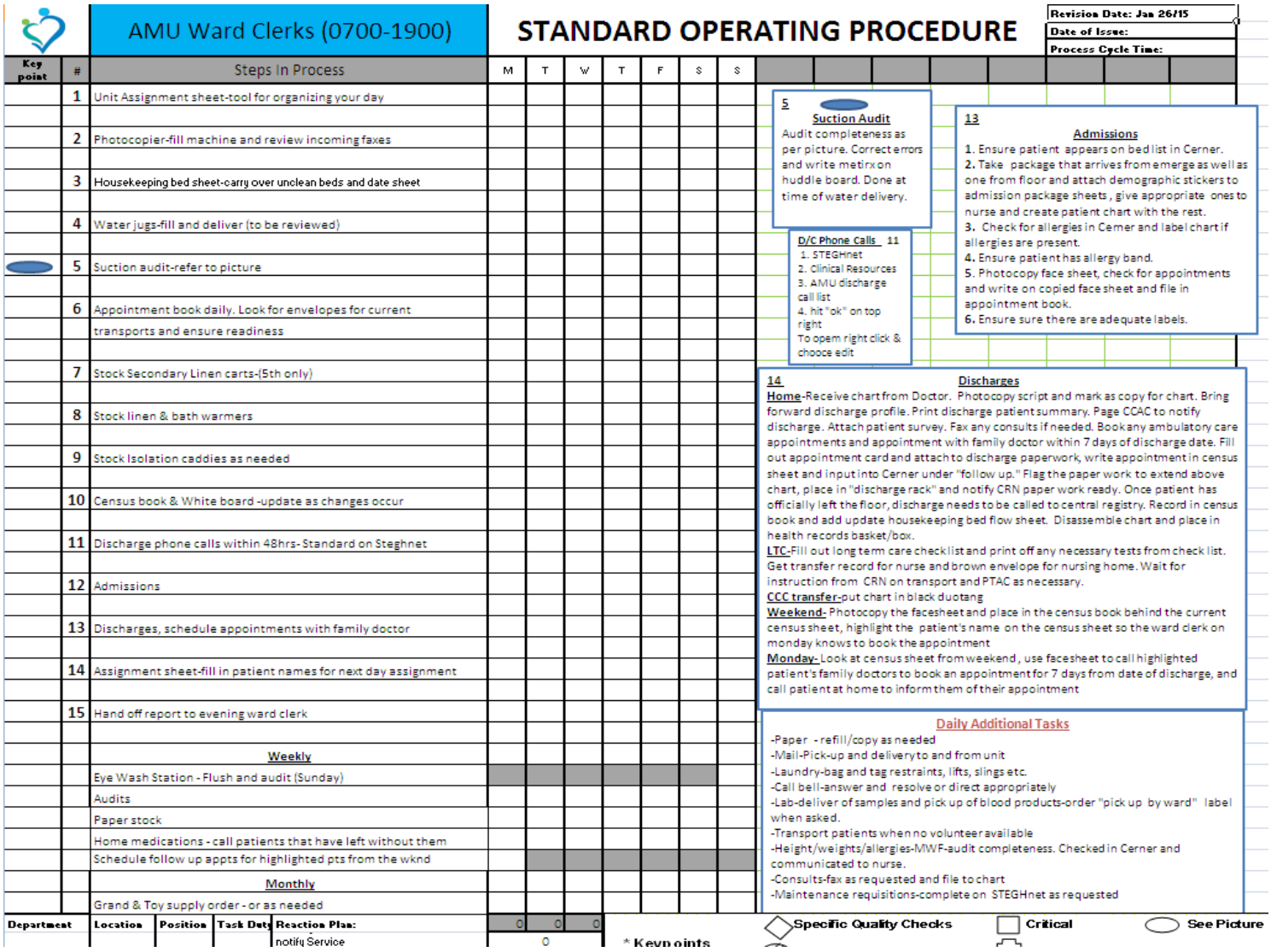
1. A Primary Care Performance Measurement Framework for Ontario: Report of the Steering Committee for the Ontario Primary Care Performance Measurement Initiative, Phase One [Internet]. Health Quality Ontario; 2014 [cited 2016 July]. Available from: http://www.hqontario.ca/portals/0/Documents/pr/pc-performance-measurement-report-en.pdf

2. Fidahussein SS, Croghan I, Cha S, Klocke D. Posthospital follow-up visits and 30-day readmission rates in chronic obstructive pulmonary disease. Risk Manag Healthc Policy. 2014;*7*:105-112.

3. 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

Appendix A:
Sample Standard Operating Procedure for Pre-Booking Primary Care Visits
(St. Thomas Elgin General Hospital process, led by the ward clerk)

Released September 2016



AMU Ward Clerks (0700-1900)

STANDARD OPERATING PROCEDURE

Revision Date: Jan 26/15
Date of Issue:
Process Cycle Time:

Key point	#	Steps In Process	M	T	W	T	F	S	S
	1	Unit Assignment sheet-tool for organizing your day							
	2	Photocopier-fill machine and review incoming faxes							
	3	Housekeeping bed sheet-carry over unclean beds and date sheet							
	4	Water jugs-fill and deliver (to be reviewed)							
⬭	5	Suction audit-refer to picture							
	6	Appointment book daily. Look for envelopes for current transports and ensure readiness							
	7	Stock Secondary Linen carts-(5th only)							
	8	Stock linen & bath warmers							
	9	Stock Isolation caddies as needed							
	10	Census book & White board -update as changes occur							
	11	Discharge phone calls within 48hrs- Standard on Steghnet							
	12	Admissions							
	13	Discharges, schedule appointments with family doctor							
	14	Assignment sheet-fill in patient names for next day assignment							
	15	Hand off report to evening ward clerk							
		Weekly							
		Eye Wash Station - Flush and audit (Sunday)							
		Audits							
		Paper stock							
		Home medications - call patients that have left without them							
		Schedule follow up appts for highlighted pts from the wknd							
		Monthly							
		Grand & Toy supply order - or as needed							

Department	Location	Position	Task Duty	Reaction Plan:			
				notify Service	0	0	0

0 * Key points

5 ⬭
Suction Audit
Audit completeness as per picture. Correct errors and write metirx on huddle board. Done at time of water delivery.

D/C Phone Calls 11
1. STEGHnet
2. Clinical Resources
3. AMU discharge call list
4. hit "ok" on top right
To opem right click & chooce edit

13
Admissions
1. Ensure patient appears on bed list in Cerner.
2. Take package that arrives from emerge as well as one from floor and attach demographic stickers to admission package sheets, give appropriate ones to nurse and create patient chart with the rest.
3. Check for allergies in Cerner and label chart if allergies are present.
4. Ensure patient has allergy band.
5. Photocopy face sheet, check for appointments and write on copied face sheet and file in appointment book.
6. Ensure sure there are adequate labels.

14 **Discharges**
Home-Receive chart from Doctor. Photocopy script and mark as copy for chart. Bring forward discharge profile. Print discharge patient summary. Page CCAC to notify discharge. Attach patient survey. Fax any consults if needed. Book any ambulatory care appointments and appointment with family doctor within 7 days of discharge date. Fill out appointment card and attach to discharge paperwork, write appointment in census sheet and input into Cerner under "follow up." Flag the paper work to extend above chart, place in "discharge rack" and notify CRN paper work ready. Once patient has officially left the floor, discharge needs to be called to central registry. Record in census book and add update housekeeping bed flow sheet. Disassemble chart and place in health records basket/box.
LTC-Fill out long term care checklist and print off any necessary tests from check list. Get transfer record for nurse and brown envelope for nursing home. Wait for instruction from CRN on transport and PTAC as necessary.
CCC transfer-put chart in black duotang
Weekend- Photocopy the facesheet and place in the census book behind the current census sheet, highlight the patient's name on the census sheet so the ward clerk on monday knows to book the appointment
Monday- Look at census sheet from weekend, use facesheet to call highlighted patient's family doctors to book an appointment for 7 days from date of discharge, and call patient at home to inform them of their appointment

Daily Additional Tasks
-Paper - refill/copy as needed
-Mail-Pick-up and delivery to and from unit
-Laundry-bag and tag restraints, lifts, slings etc.
-Call bell-answer and resolve or direct appropriately
-Lab-deliver of samples and pick up of blood products-order "pick up by ward" label when asked.
-Transport patients when no volunteer available
-Height/weights/allergies-MWF-audit completeness. Checked in Cerner and communicated to nurse.
-Consults-fax as requested and file to chart
-Maintenance requisitions-complete on STEGHnet as requested

◇ Specific Quality Checks ☐ Critical ⬭ See Picture

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

Appendix B:
Sample Discharge Alert and Request for Follow-up Appointment
(Hamilton Niagara Haldimand Brant LHIN: Transitions Discharge Bundle)

Released September 2016

Hamilton Health Sciences

Discharge Alert

Hospital Request for Follow-Up Appointment

Date: _____

Dear Dr._____

I am discharging your patient _____
Patient's Name

on _____and I am requesting a follow-up appointment in

_____ business days from the date of discharge. I am recommending that the following be addressed at this appointment :

_____

_____

_____

Please note a copy of the Discharge Orders which includes Medication Reconciliation/ Prescription will be faxed to your office on the day of discharge.

Prior to discharge from the hospital we would like to provide the patient with an appointment to see you. If your office is not able to contact the hospital to provide an appointment prior to the patient's discharge, please contact the patient directly and provide the appointment.

Thank you!

_____
Physician's name (please print) and Pager # and Service

_____ _____
Hospital Name/Telephone # Unit patient being discharged from/Extension

Please fax this form to the Family Doctor as soon as possible

Appendix C:
Measurement Specifications for Scheduling a Primary Care Visit Before Leaving Hospital

Released September 2016

1. Percentage of patients with multiple conditions and complex needs who see their primary care provider within seven (7) days after discharge from hospital

Stage of Hospital Stay	Close to the time of discharge
Innovative Practice	Schedule a primary care visit before leaving hospital
Type of Measure	Outcome Measure
Definition/Description	Ensuring that patients with multiple conditions and complex needs have a primary care provider visit pre-booked to take place within seven (7) days post hospital discharge is a key enabler of a smooth transition. Therefore, before a patient is discharged from hospital, their appointment should be scheduled and confirmed with the patient, thus improving communication and timely access to care. Dimensions: Effective, Patient Centered, Safe, Timely Direction of Improvement: ↑
Additional Specifications	Calculation Methods: Numerator/Denominator*100 Numerator: Number of patients who have multiple conditions and complex needs who attend an appointment with their primary care provider within seven (7) days of hospital discharge Denominator: Total number of discharged patients who have multiple conditions and complex needs Exclusions: Patients who are deemed “no show”; patients who are rehospitalized within the given time period; patients who die before the time of the scheduled appointment
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 experienced an unplanned readmission to hospital within thirty (30) days of discharge

Stage of Hospital Stay	Close to the time of discharge
Innovative Practice	Schedule a primary care visit before leaving hospital
Type of Measure	Outcome Measure
Definition/Description	Ensuring that patients with multiple conditions and complex needs have a primary care provider visit pre-booked to take place within seven (7) days post hospital discharge is a key enabler of a smooth transition. Therefore, before a patient is discharged from hospital, their appointment should be scheduled and confirmed with the patient, thus improving communication and timely access to care. 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 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.

3. Percentage of patients with multiple conditions and complex needs who have a primary care provider appointment that was pre-booked prior to leaving hospital

Stage of Hospital Stay	Close to the time of discharge
Innovative Practice	Schedule a primary care visit before leaving hospital
Type of Measure	Process Measure
Definition/Description	Ensuring that patients with multiple conditions and complex needs have a primary care provider visit pre-booked to take place within seven (7) days post hospital discharge is a key enabler of a smooth transition. Therefore, before a patient is discharged from hospital, their appointment should be scheduled and confirmed with the patient, thus improving communication and timely access to care. Dimensions: Effective, Patient Centered, Safe, Timely Direction of Improvement: ↑
Additional Specifications	Calculation Method: Numerator/Denominator*100 Numerator: Number patients who have multiple conditions and complex needs who are hospitalized and who have an appointment pre-booked for follow-up with their primary care provider within seven days of discharge prior to leaving the hospital Denominator: Total number of discharged patients who have multiple conditions and complex needs Exclusion Criteria: Patients who are not offered a pre-booked appointment. 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. **The sample total of indicators 3-6 should equal 100%.**
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 identified as no-shows to their follow-up appointment with their primary care provider appointment that was pre-booked to occur within seven (7) days post hospital discharge

Stage of Hospital Stay	Close to the time of discharge
Innovative Practice	Schedule a primary care visit before leaving hospital
Type of Measure	Process Measure
Definition/Description	Ensuring that patients with multiple conditions and complex needs have a primary care provider visit pre-booked to take place within seven (7) days post hospital discharge is a key enabler of a smooth transition. Therefore, before a patient is discharged from hospital, their appointment should be scheduled and confirmed with the patient, thus improving communication and timely access to care. 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 appointment booked with their primary care provider prior to hospital discharge but do **NOT** arrive to the appointment Denominator: Total number of discharged patients who have multiple conditions and complex needs Exclusions: Patients who are re-hospitalized; patients who die before the time of the scheduled appointment; patients who reschedule the appointment
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. **The sample total of indicators 3-6 should equal 100%.**
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 with multiple conditions and complex needs who are unable to be pre-booked within seven (7) days post discharge due to primary care availability

Stage of Hospital Stay	Close to the time of discharge
Innovative Practice	Schedule a primary care visit before leaving hospital
Type of Measure	Process Measure
Definition/ Description	Ensuring that patients with multiple conditions and complex needs have a primary care provider visit pre-booked to take place within seven (7) days post hospital discharge is a key enabler of a smooth transition. Therefore, before a patient is discharged from hospital, their appointment should be scheduled and confirmed with the patient, thus improving communication and timely access to care. 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 are unable to have an appointment pre-booked within seven (7) days of discharge due to lack of primary care availability. Denominator: Total number of discharged patients who have multiple conditions and complex needs Exclusions: Patients who are re-hospitalized; patients who die before the time of the scheduled appointment
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. **The sample total of indicators 3-6 should equal 100%.**
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.

6. Percentage of patients with multiple conditions and complex needs who decline an offer for an appointment within seven (7) days of discharge

Stage of Hospital Stay	Close to the time of discharge
Innovative Practice	Schedule a primary care visit before leaving hospital
Type of Measure	Process Measure
Definition/Description	Ensuring that patients with multiple conditions and complex needs have a primary care provider visit pre-booked to take place within seven (7) days post hospital discharge is a key enabler of a smooth transition. Therefore, before a patient is discharged from hospital, their appointment should be scheduled and confirmed with the patient, thus improving communication and timely access to care. 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 decline having an appointment pre-booked with their primary care provider within seven days of discharge Denominator: Total number of discharged patients with multiple conditions and complex needs Exclusions: Patients who are re-hospitalized; patients who die before the time of the scheduled appointment
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. **The sample total of indicators 3-6 should equal 100%.**
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.

7. Average number of days to follow-up appointment for patients with multiple conditions and complex needs post discharge

Stage of Hospital Stay	Close to the time of discharge
Innovative Practice	Schedule a primary care visit before leaving hospital
Type of Measure	Process Measure
Definition/Description	Ensuring that patients with multiple conditions and complex needs have a primary care provider visit pre-booked to take place within seven (7) days post hospital discharge is a key enabler of a smooth transition. Therefore, before a patient is discharged from hospital, their appointment should be scheduled and confirmed with the patient, thus improving communication and timely access to care. Dimensions: Effective, Patient Centered, Safe, Timely Direction of Improvement: ↓
Additional Specifications	Calculation Method: Numerator/Denominator Numerator: Sum of the total number of days from discharge to the follow-up appointment Denominator: Total number of discharged patients who have multiple conditions and complex needs Exclusions: Patients who are discharged without a follow-up appointment with primary care
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.