Transitions Between Hospital and Home

Summary of Innovative Practices

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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*.

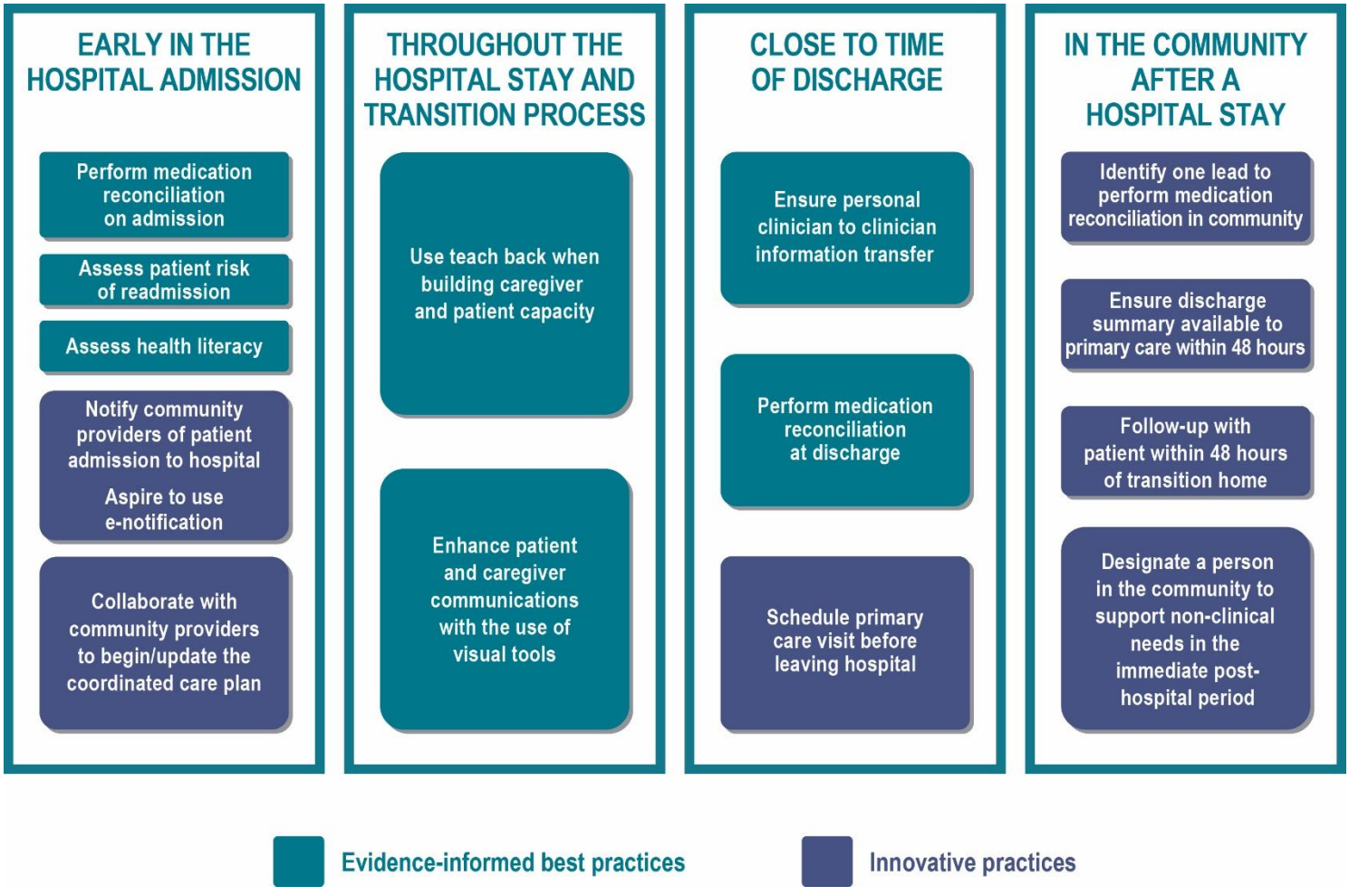

Figure 1: Practices to Improve Transitions Between Hospital and Home

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

Quality Improvement: Getting Started

Quality improvement (QI) offers a proven methodology for improving care for patients, residents and clients. QI refers to a team working **towards a defined aim**, gathering and reviewing data to inform their progress and implementing change strategies using rapid cycle improvements. QI science provides **tools and processes** to assess and accelerate efforts for testing, implementing and spreading QI practices. *For additional information on Quality Improvement, please visit:* http://qualitycompass.hqontario.ca/portal/getting-started#.V1rU7bsrK00 or *contact **QI@hqontario.ca** for access to e-learning modules.*

Innovative Practices

Innovative practices are based on the highest quality evidence and information available and have been defined and assessed by a Clinical Reference Panel[1]. It is suggested that Health Links draw upon this collection of Innovative Practices to create the foundation for supporting their processes and improving transitions for patients within their Health Link.

Throughout these toolkits you will notice that a particular clinical role is not identified to conduct activities associated with the innovative practices. It is suggested that each Health Link identify the most appropriate person for the activities within their local context. **Listed below you will find the selected Innovative Practices relating to Transitions between Hospital and Home**. These practices were selected using a comprehensive environmental scan, evaluated using the **Innovative Practices Evaluation Framework,** and reviewed by the **Health Links Clinical Reference Panel** in June 2016. *For additional information regarding this process and assessment criteria, please visit* http://www.hqontario.ca/Portals/0/documents/bp/bp-inovative-practices-en.pdf.

Steps for Transitions between Hospital and Home	Innovative Practice	Innovative Practice Assessment	Clinical Reference Group Endorsement for Spread
Early in the Hospital Admission	Notify community providers of patient admission to hospital Aspire to use e-Notification	**PROMISING**	Provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (September 2017).
	Collaborate in hospital with community providers to begin/update the coordinated care plan	**EMERGING**	
Close to the Time of Discharge	Schedule primary care visit before leaving hospital	**PROMISING**	
In the Community After A Hospital Stay	Identify one lead to perform medication reconciliation in the community	**PROMISING**	
	Ensure discharge summary available to primary care within 48 hours of discharge	**PROMISING**	
	Follow-up with patient within 48 hours of transition home	**EMERGING**	
	Designate a person in the community to support non-clinical needs in the immediate post-hospital period	**EMERGING**	

For additional information, please visit the Tools and Resources Tab in the Health Links section of the Health Quality Ontatio at: http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links.

[1] *The Clinical Reference Panel is composed of subject matter experts in Health Links, researchers, academia, and stakeholders from across the province.*

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#.V1rU7bsrK00.

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.

Steps for Transitions between Hospital and Home	Innovative Practice	Outcome Measures *Are the changes having the intended impact?*	Process Measures *Are the practices being implemented as planned?*
Early in the Hospital Admission	Notify community providers of patient admission to hospital Aspire to use e-Notification	• Percentage of patients with multiple conditions and complex needs who experienced an unplanned readmission to hospital within thirty (30) days of discharge.*	• Percentage of patient admission notifications or e-notifications sent to primary care providers (PCP). • 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.
Early in the Hospital Admission	Collaborate in hospital with community providers to begin/update the coordinated care plan	• Number of coordinated care plans developed or updated at least once with the patient during hospital admission	• Percentage of single points of contact (identified prior to hospitalization) that collaborated on updates to the coordinated care plan while patient is in hospital • Percentage of patients with multiple conditions and complex needs involved in developing and/or updating their coordinated care plan while in hospital
Close to the Time of Discharge	Schedule primary care visit before leaving hospital	• Percentage of patients who have multiple conditions and complex needs who see their primary care provider within seven days (7) after discharge from hospital* • Percentage of patients with multiple conditions and complex needs who	• 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 • Percentage of patients with multiple conditions and complex needs **identified as no-shows** to their follow-up appointment with their primary care provider appointment

Steps for Transitions between Hospital and Home	Innovative Practice	Outcome Measures *Are the changes having the intended impact?*	Process Measures *Are the practices being implemented as planned?*
		experienced an unplanned readmission to hospital within thirty (30) days of discharge*	that was pre-booked to occur within seven (7) days post hospital discharge • 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 • Percentage of patients with multiple conditions and complex needs who **decline** an offer for an appointment within seven (7) days of discharge • Average number of days to primary care follow-up appointment for patients who have multiple conditions and complex needs post discharge
In the Community After A Hospital Stay	Identify one lead to perform medication reconciliation in the community	• Percentage of medication errors for patients with multiple conditions and complex needs that lead to an emergency department visit • Number of medication discrepancies for patients with multiple conditions and complex needs (error did not reach the patient)	• Percentage of patients with multiple conditions and complex needs for whom one lead is identified for medication reconciliation • Number of medication reconciliations completed per patient with multiple conditions and complex needs in the community post discharge • Staff satisfaction related to medication reconciliation process
In the Community After A Hospital Stay	Ensure discharge summary available to primary care within 48 hours of discharge	• Percentage of patients with multiple conditions and complex needs who visit the emergency department within seven (7) days post discharge for a similar condition.	• Percentage of discharge summaries for patients with multiple conditions and complex needs made available to PCPs within 48 hours of discharge.*
In the Community After A Hospital Stay	Follow-up with patient within 48 hours of transition home	• Percentage of patients with multiple conditions and complex needs who visit the emergency department within seven (7) days post discharge	• Time between discharge of patient and follow up phone call • Percentage of patients with multiple conditions and complex needs who identify new issues during the 48-hour follow-up phone call that were

Steps for Transitions between Hospital and Home	Innovative Practice	Outcome Measures *Are the changes having the intended impact?*	Process Measures *Are the practices being implemented as planned?*
		• Percentage patients with multiple conditions and complex needs who experienced an unplanned readmission to hospital within 30 days of discharge.*	not previously identified at time of discharge • Percentage of patients satisfied with 48-hour post discharge follow up phone call
In the Community After A Hospital Stay	Designate a person in the community to support non-clinical needs in the immediate post-hospital period	• 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**	• 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 • Satisfaction of patient who has multiple conditions and complex needs with the involvement of the support person(s) in the community

*This suggested measure is closely aligned to the indicator in Quality Improvement Plans (QIP).
** This suggested measure is closely aligned to the Common Quality Agenda indicator for caregiver distress.