Health Links Leadership Community of Practice

Nov 16, 2016

Innovative Practices: Transitions Between Hospital and Home – Part 2

Today's Agenda

- Overview of Innovative Practices for *Transitions Between Hospital to Home*
- Deep dive into final 4 Innovative Practices and guest speakers
- Discussion: Implementing Innovative Practices in your Health Link
- Upcoming Events

Webinar Learning Objectives

- Gain an understanding and learn more about the Innovative Practices for *Transitions Between Hospital and Home*
- Reflect on the impacts to patients as these practices are implemented
- Collaborate with your colleagues and hear about how these practices may be implemented in your Health Links
- Understand the purpose and approach to measuring the impact of the practices

PARTICIPATING IN THE WEBINAR

- This webinar is being *recorded*.
- ALL participants will be muted (to reduce background noise). You can access your webinar options via the orange arrow button.
- Discussion period post presentation, please type your questions for the presenter after each presentation.
- If you would like to submit a question or comment at any time, please use Question box feature.

WEBINAR PANEL

Susan Taylor, *Director, Quality Improvement Program Delivery, Health Quality Ontario*

Caroline Buonocore, *Quality Improvement Specialist, Health Quality Ontario*

Monique LeBrun *Quality Improvement Specialist, Health Quality Ontario (Moderating Discussion)*

GUEST SPEAKERS

Laurie French and Andrea Campbell, SE LHIN region

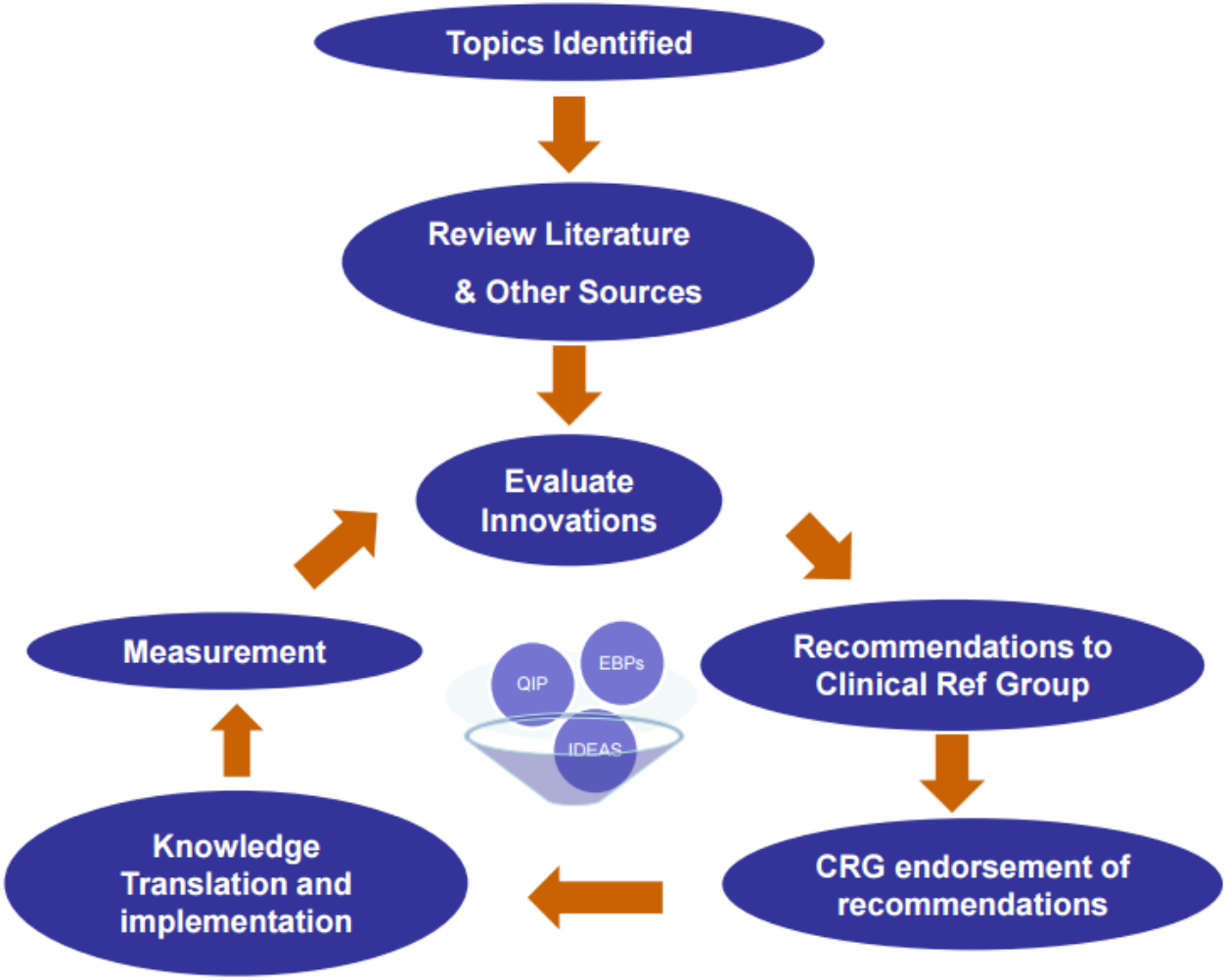
Tania Pinheiro and Emily Sheridan, SW LHIN region

Jane McKinnon, WW LHIN region

HEALTH LINKS LEADERSHIP COMMUNITY OF PRACTICE

'Communities of practice can be defined as groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly'

INNOVATIVE PRACTICES

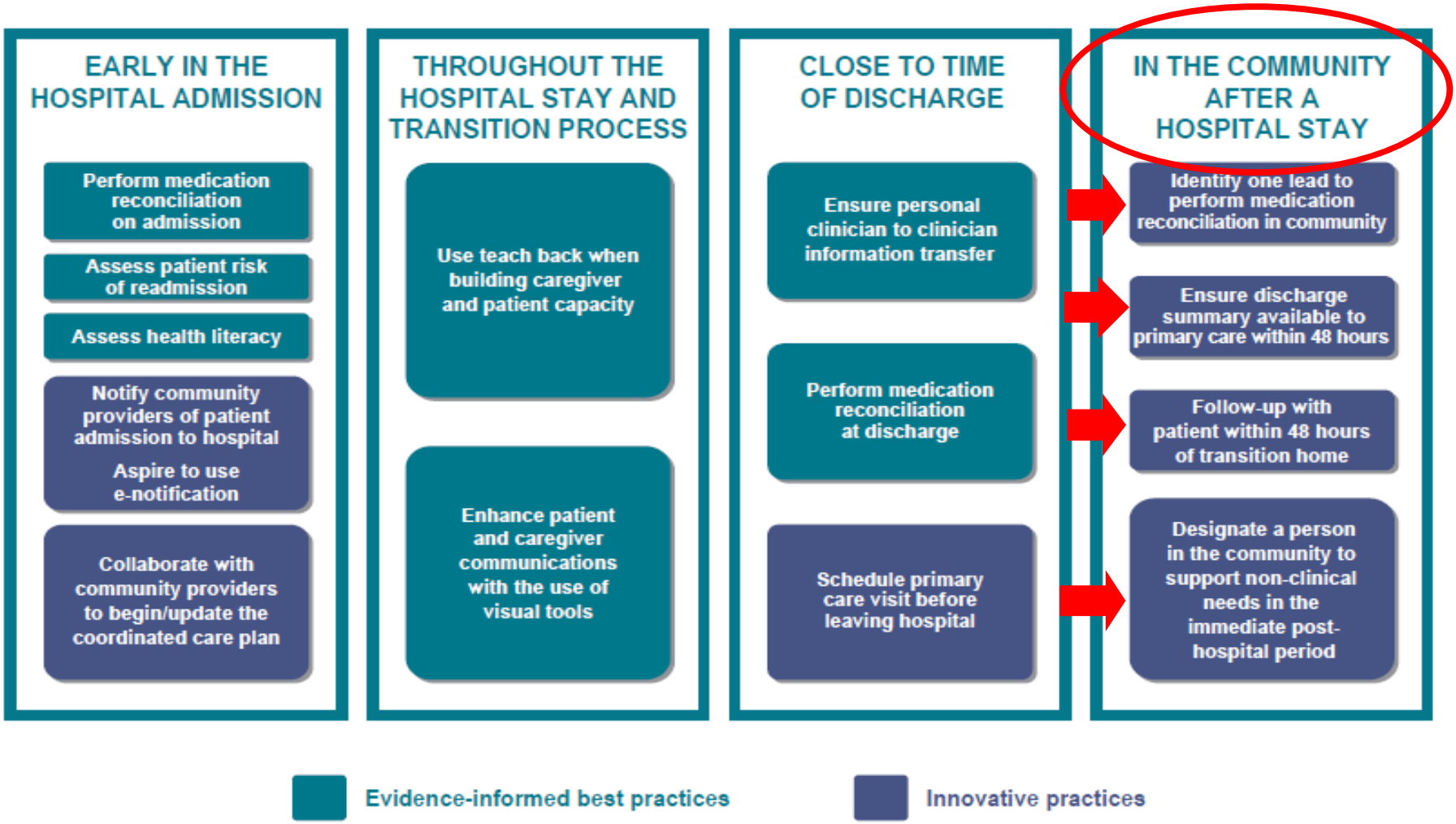


Transitions Between Hospital and Home

An important part of providing coordinated care to patients is improving patient transitions within the system to help ensure patients receive more responsive care that addresses their specific needs.

OVERVIEW OF PRACTICES FOR TRANSITIONS BETWEEN HOSPITAL & HOME

Transitions between Hospital to Home



Evidence-Informed Best Practices

Steps for Transitions between Hospital and Home	Evidence-Informed Best Practice (cited in Quality Compass*)
Early in the Hospital Admission	Perform medication reconciliation on admission
	Assess patient risk of readmission
	Assess health literacy
Throughout the Hospital Stay and Transition Process	Use teach back when building caregiver and patient capacity
	Enhance patient and caregiver communications with the use of visual tools
Close to the Time of Discharge	Ensure personal clinician to clinician transfer
	Perform medication reconciliation at discharge

Summary of Innovative Practices

Steps for Transitions between Hospital and Home	Innovative Practice	Innovative Practice Assessment
Early in the Hospital Admission	Notify community providers of patient admission to hospital Aspire to use e-Notification	PROMISING
	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

Innovative Practices for Transitions Between Hospital to Home

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IN THE COMMUNITY AFTER A HOSPITAL STAY

- Identify one lead to perform medication reconciliation in community
- Ensure discharge summary available to primary care within 48 hours
- Follow-up with patient within 48 hours of transition home
- Designate a person in the community to support non-clinical needs in the immediate post-hospital period

Ontario

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*.

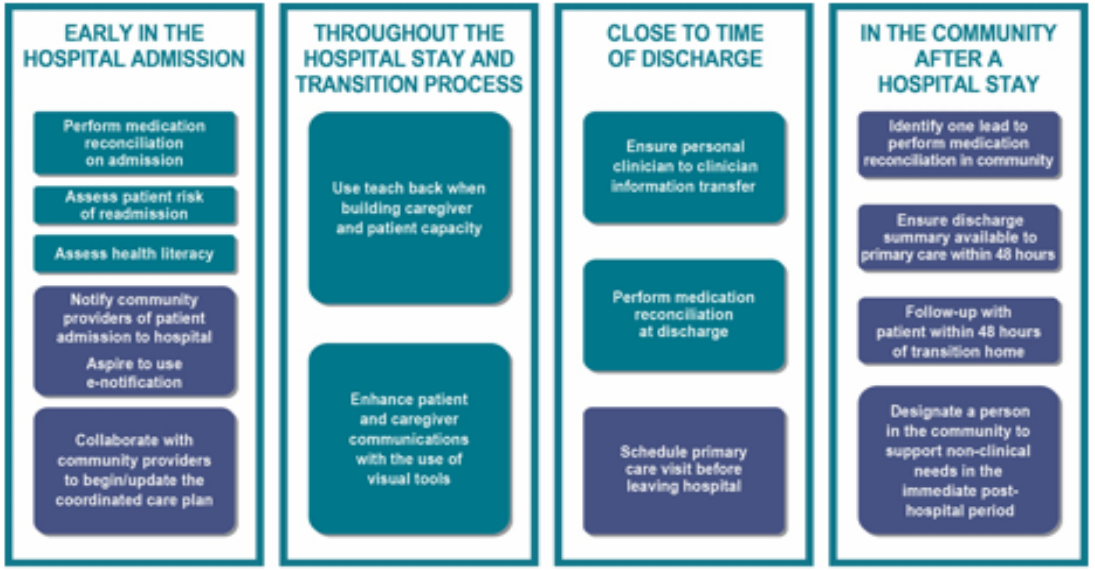

Figure 1: Practices to Improve Transitions Between Hospital and Home

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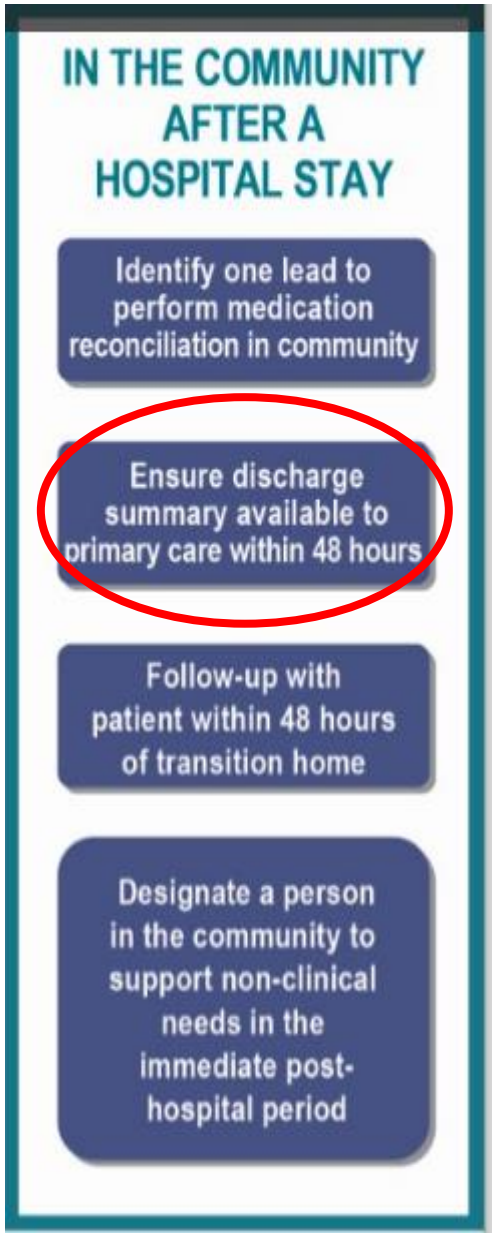
Suggested Steps & Measures

1. Select medication reconciliation lead
2. Medication reconciliation lead commits
3. Perform medication reconciliation and update Coordinated Care Plan (CCP)
4. Share CCP with care team

Suggested Outcome Measures	Suggested Process Measures
Percentage of medication errors for patients with multiple conditions and complex needs that lead to an emergency department visit	Percentage of patients with multiple conditions and complex needs for whom one lead is identified for medication reconciliation
Number of medication discrepancies for patients with multiple conditions and complex needs (error did not reach the patient)	Number of med rec's completed per patient with multiple conditions and complex needs in the community post discharge
	Staff satisfaction related to medication reconciliation process



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Transitions Between Hospital and Home

In the Community Post Hospital Stay: Ensure Discharge Summary Available to Primary Care within 48 hours

Released September 2016

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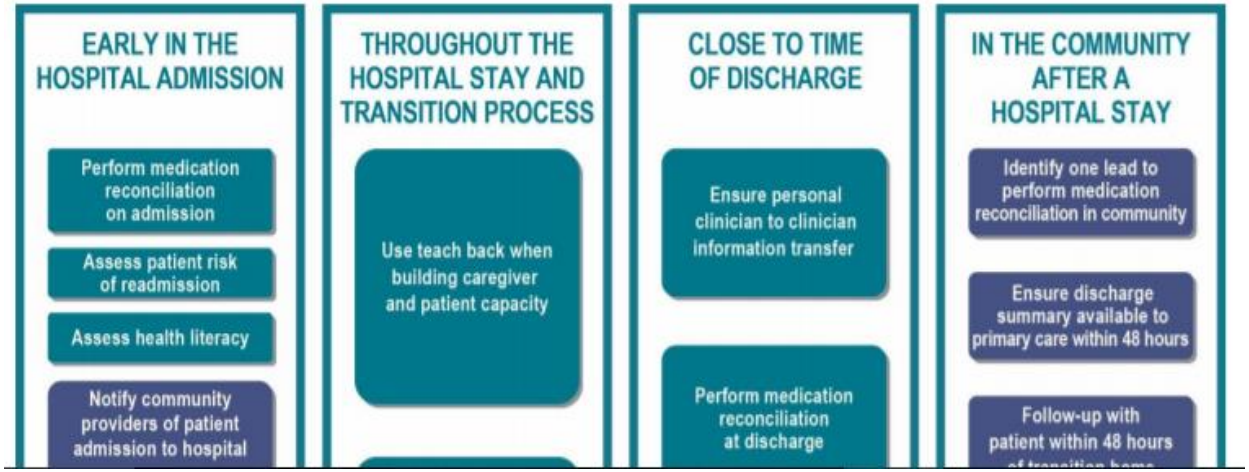

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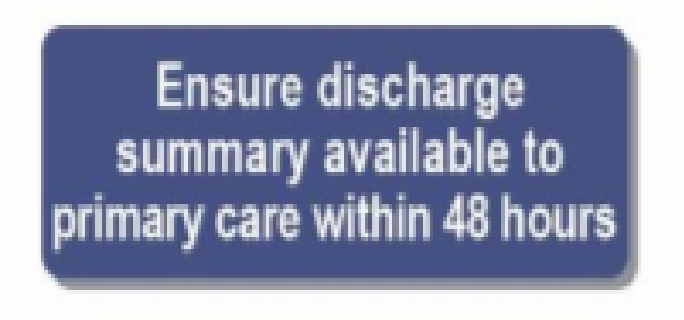
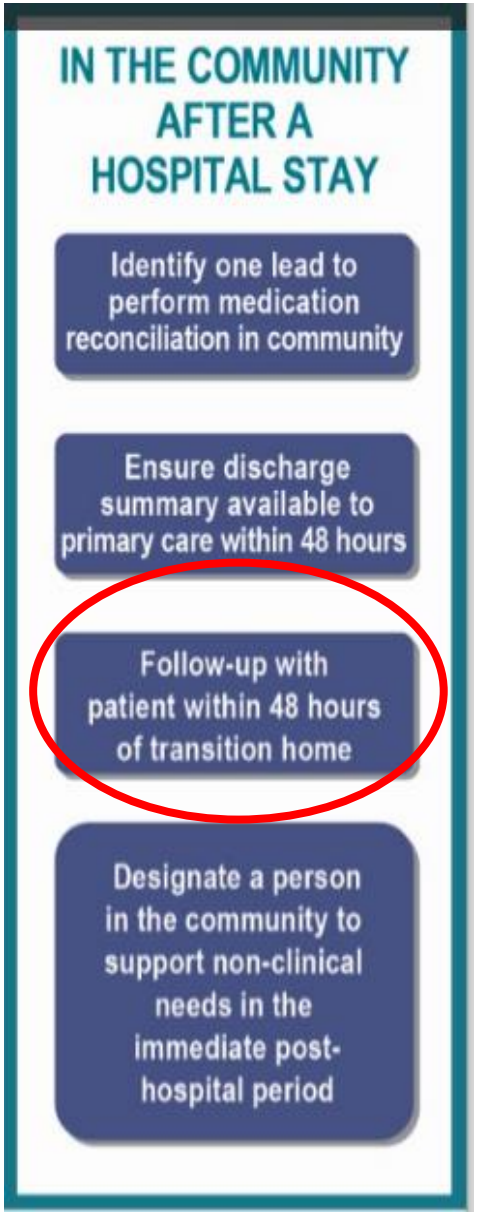
Suggested Steps & Measures



1. Create in-hospital processes to have discharge summary completed and sent within 48 hours.
2. Primary Care Provider (PCP) alerted of available discharge summary

Suggested Outcome Measures	Suggested Process Measures
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.* *This suggested measure is closely aligned to the indicator in Quality Improvement Plans (QIP).



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Transitions Between Hospital and Home

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

Released September 2016

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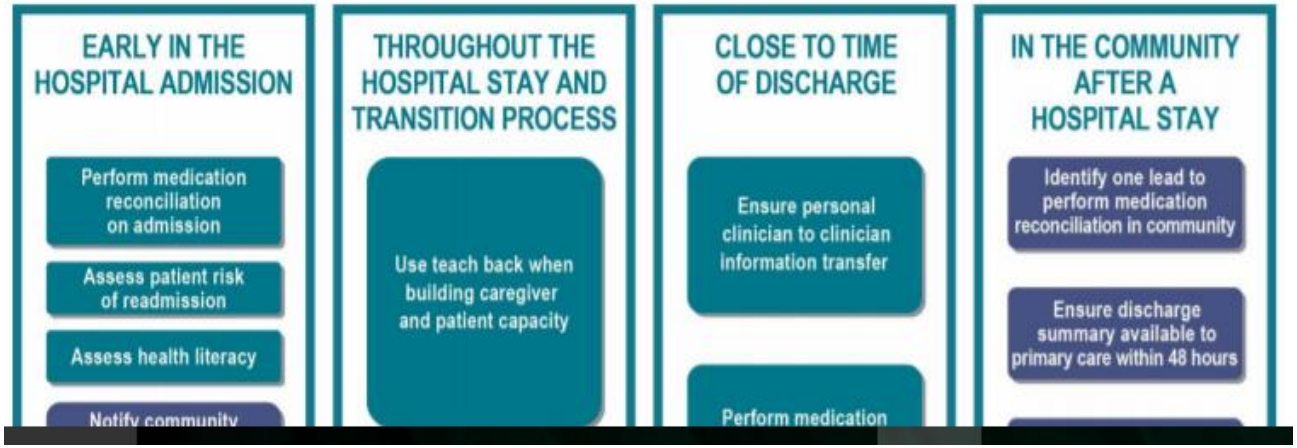

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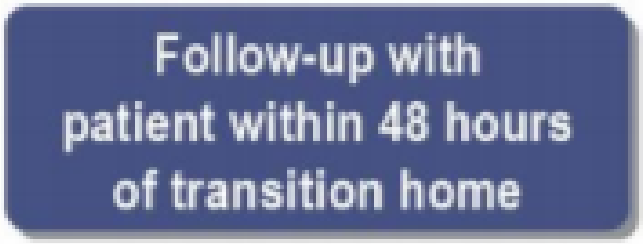
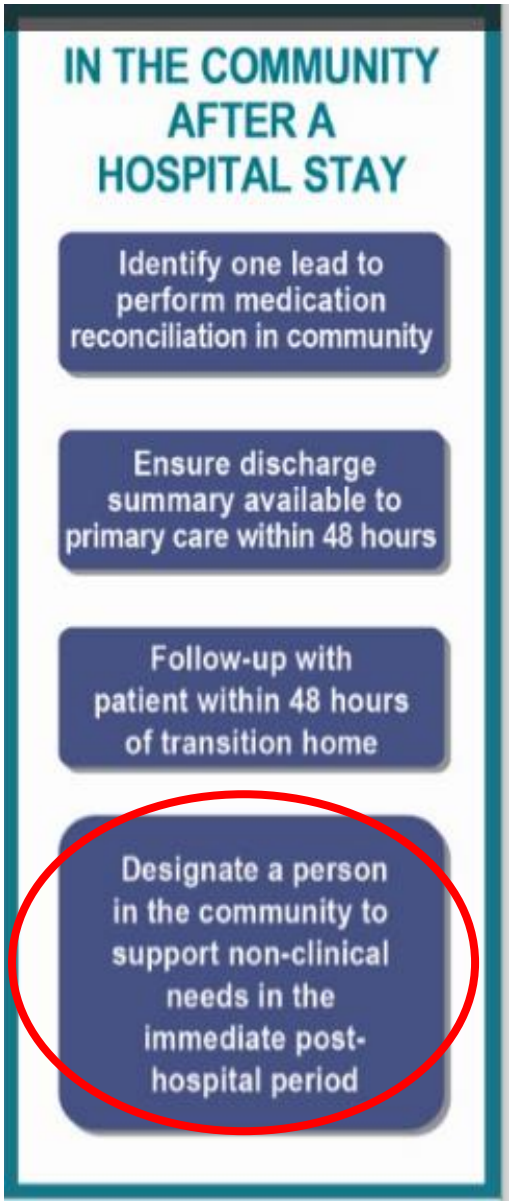
Suggested Steps & Measures



1. Provider with existing relationship place follow-up call within 48 hours of discharge
2. Use a standard approach or script

Suggested Outcome Measures	Suggested Process Measures
Percentage of patients with multiple conditions and complex needs who visit the emergency department within seven (7) days post discharge Percentage patients with multiple conditions and complex needs who experienced an unplanned readmission to hospital within 30 days of discharge.* *This suggested measure is closely aligned to the indicator in Quality Improvement Plans (QIP).	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 not previously identified at time of discharge Percentage of patients satisfied with 48-hour post discharge follow up phone call



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Transitions Between Hospital and Home

In the Community Post Hospital Stay: Designate a Person in the Community to Support Non-Clinical Needs in the Immediate Post-Hospital Period

Released September 2016

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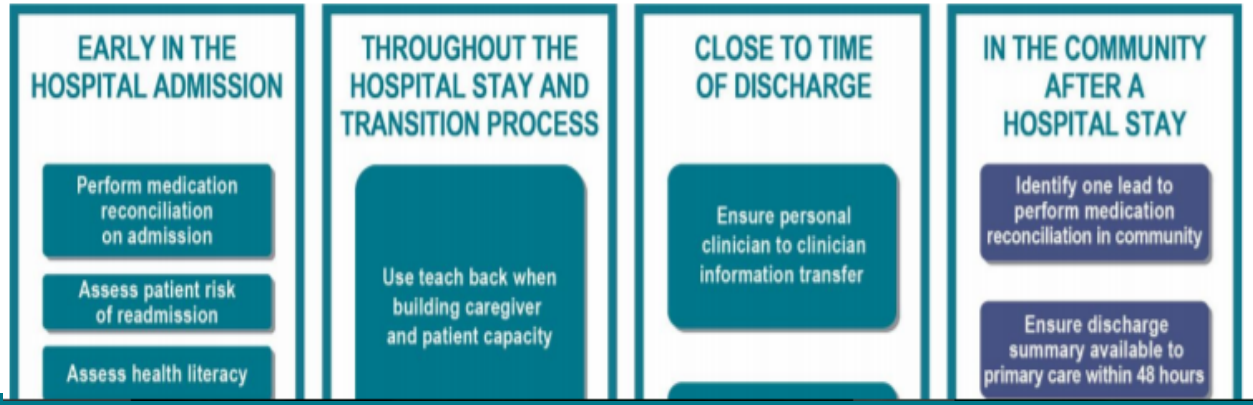

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Suggested Steps & Measures

1. Perform a gap analysis for required home supports
2. Identify lead or agency/organization that could fill the role
3. Connect with circle of care and update the Coordinated Care Plan

Suggested Outcome Measures	Suggested Process Measures
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.

Practices from the Field

Early Identification of Health Link Patients in Hospital for a Seamless Transition to Home

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South East CCAC
Rapid Response Nurses (RRN) and Medication Reconciliation: Collaboration in Action

Diligence to Practice :
Innovative Practices for Transitions Between Hospital and Home

Andrea Campbell Nurse Practitioner
Laurie French Senior Manager

November 16 ,2016

Medication Reconciliation as a component of Direct Care

- Best Possible Medication History (BPMH): A current medication history which includes all regular and "as needed" (prn) medication used (prescribed and non-prescribed) using a number of different sources including the client/family/caregiver interview.
- It is about the conversation and then a series of sequenced steps and processes that lead to BPMH.

Summary of the SECCAC RRN Health Links Pilot

- The Rural Kingston Health Link undertook an improvement opportunity with the IDEAS program with HQO in 2016 involved the Rapid Response Nurse (RRN) and Manager in that area.
- Diligence in practice – to improve communication of medication use during transitions with a focus on complex patients.
- Incorporated leading clinical guidelines/safety, understanding, independence, self care and BPMH.
- Influenced expansion of the original criteria for RRN beyond hospital referrals to include community complex HL patients to further avoid hospital readmission and increased care in the client's /patient's home.
- Outcomes for patients, families, caregivers, healthcare providers improved with communication and collaboration.

What are we doing now ?

- All direct care nurses in CCAC now perform med reconciliation at first visit.
- Standardized forms are being used with specific changes adaptable to prescribers (NP's) and Non Prescribers (MHAN,RRN).
- Education and standard medication management policies for all staff developing from OACCAC/ISMP that meets criteria for patient/client safety, accreditation standards and are based on leading practice to provide our patients the best possible service and quality of care.

PATIENTS FIRST: IMPROVING COMMUNICATION OF CURRENT MEDICATION USE DURING TRANSITIONS
Rural Kingston Health Link

Annie Campbell RN, Verona Medical Clinic, Delanya Podgers NP, Kingston General Hospital, Kris Walker RN, South East CCAC, Laurel Dempsey MD, Verona Medical Clinic

By 30 June 2015, 75% of complex patients at Verona Medical Clinic will have a best possible medication history documented in the primary care record

- Primary care serves a coordinating function for all of a patient's care and medication management
- Good fit for addressing challenges in medications for complex patients with multiple touch points in the system

Objectives

- Complete and maintain an accurate medication list
- Develop best inter-provider communications practices
- Reduce adverse events
- Engage patients in their care

Change Ideas

- Identify complex patients and create database to track encounters
- Ask complex patients to bring all medications to appointments
- All Complex patients referred to CCAC Rapid Response Nurses (RRN) post ED visit or hospital admission
- Primary Care appointment for Complex patients within 7 days of discharge / ED visit
- RRN visits to identified non-acute complex patients currently on CCAC services for medication reconciliation
- Development of a patient education pamphlet to promote patient engagement

Family of Measures

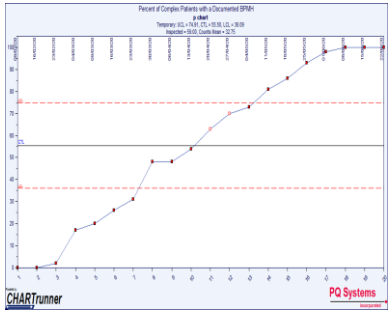
OUTCOME MEASURE:
- Percent of patients with BPMH documented in the primary care record

PROCESS MEASURES
- Patients with a BPMH documented 7 days post-discharge
- Patients with BPMH documented post ambulatory care visits
- Patients visited by Rapid Response Nurse

Results

100% of identified complex patient have a BPMH documented in the primary care record.
- 74% documented in primary care
- 18% completed by the RRN
- 8% completed using the acute care discharge summary

RRN Visited 11 complex patients
- 4 following ED visit or admission
- 7 non-acute visits



Organizational Enablers

RESOURCES:
- Support staff time from 4 organizations and the SELHIN
- Funding to support IDEAS attendance

PEOPLE:
- Patient participation
- Physician participation
- Front line staff motivations
- Development of QI knowledge and expertise

ORGANIZATIONAL ENABLERS:
- Ready and eager cooperation of all organizational partners
- Culture supportive of productive change
- Support of the SELHIN

SYSTEM ENABLERS:
- Health Link funding
- Environment of commitment to change locally and regionally

Sustainability

This is a practical and sustainable initiative within the primary care setting. It requires streamlining to make it less time-intensive. Sustainability within the electronic medical record at the primary care has been slowed by the introduction of new clinical software during the project.

Spread

KEY PLANS FOR THE FUTURE:

- Initiative maintained and continued at Verona Medical Clinic
- Expand BPMH process to Health Link Seniors' Mental Health Program
- Engage additional physician and nursing providers within the Rural Kingston Health Link through site presentations to six clinical practices
- Work with Telus to determine EMR capabilities with respect to reducing the data workload burden
- SE CCAC is developing a similar RRN process with other Health Links

Lessons Learned

The following factors are key:
- Patient engagement (a very positive experience)
- Physician and nursing engagement in all stages of the project
- Robust cross-sectoral partnerships
- Collect more data than you think you may need

Contact

Name: Lynn Wilson
Title: Administrative Lead
Organization: Rural Kingston Health Link
Email: wilsonl1@kgh.kari.net
Phone:613-374-3311

Why is this important ?

- **Transitions between hospital and home (including Long term care) have a greater risk of a medication related readmission to hospital and impacts the overall safety and well being of the patient.**

Patients at risk of a medication related readmission :

- **Taking 5 or more medications**
- **Multiple medication changes while in hospital**
- **Taking high-risk medications (BEERS CRITEIARIA)**
- **Previously hospitalized for an adverse drug reaction**
- **Over 75 years of age**
- **Limited care supports at home**
- **If non-adherence - would cause therapeutic failure**

Source:

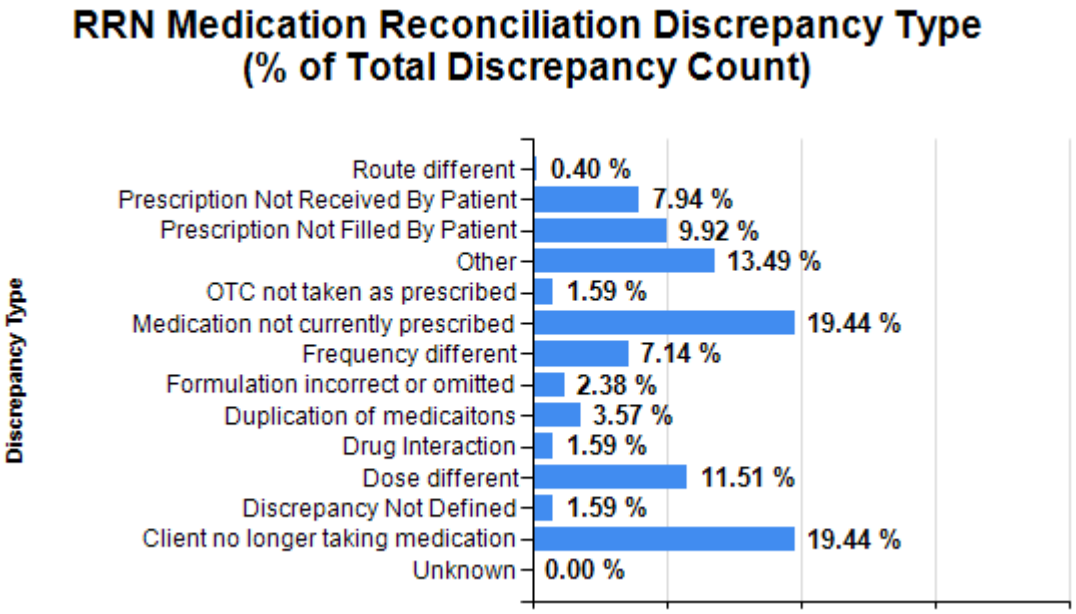
https://www.ismp-canada.org/download/transitions/Hospital2home_poster201502.pdf

Collaboration at it's best

- Utilizing community expertise
- Engaging families and patients
- Communication with Primary Care Providers
- Documentation standards (speak the same language)
- Reduction of readmission & ER visits, less complications as a result of readmission for frail elderly or complex chronic patients
- Increased ability, confidence and self- care for patients /caregivers and LTC health care providers
- Education for health care providers
- Streamlining med reconciliation forms for prescribers and non prescribers to capture essential elements
- Ongoing communication and partnering

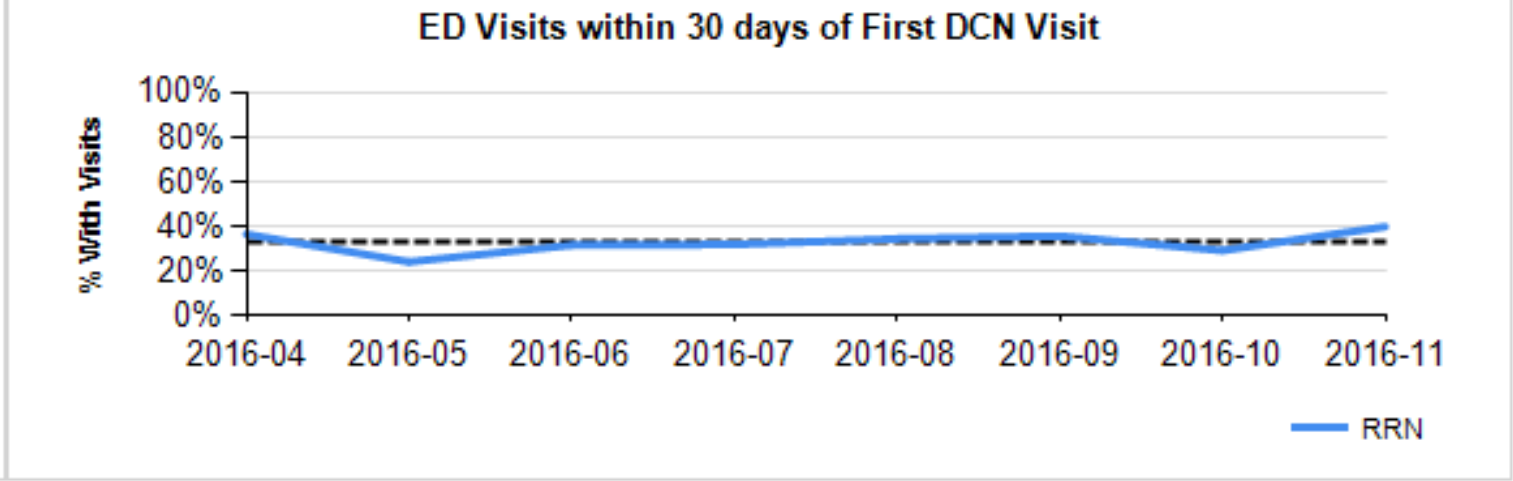
Statistically speaking : Results are in the Reconciliation

- **98.64%** of patients receive a full med rec at the RRN visit (April–October 2016)
- **32.8 %** of patients had an identified discrepancy as per our definition;



Emergency Department Visits

- Within 30 days of first Direct Care Nursing Visit



Emergancy Department Visits within 30 days of first Direct Care Nursing Visit

- % of patients with at least one visit to the emergancy department within 30 days of their first nursing visit

- The average # of visits for all programs combined within the selected period is represented by the dotted line

Questions & Discussion

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Optimizing the transitions of care from hospital to community

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Emergency Department
St Thomas Elgin General Hospital
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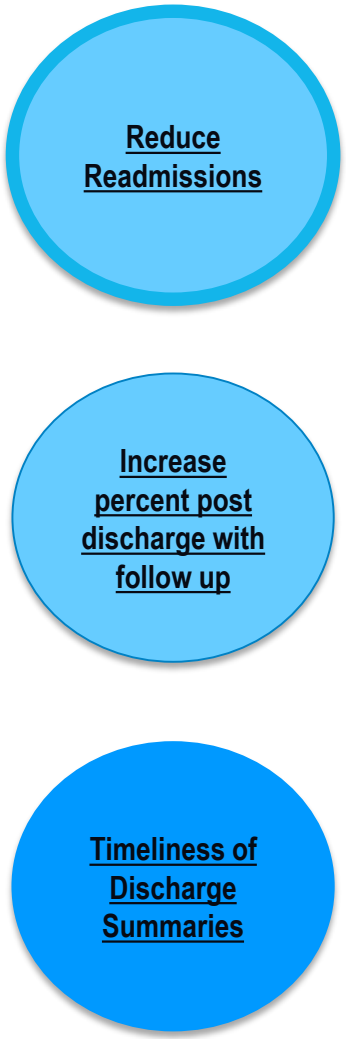
St.Thomas Elgin General Hospital

Our Aim Statement

High level Aim (goal) – *To optimize transitions of care for acute medical patients (hospital to community post discharge)*

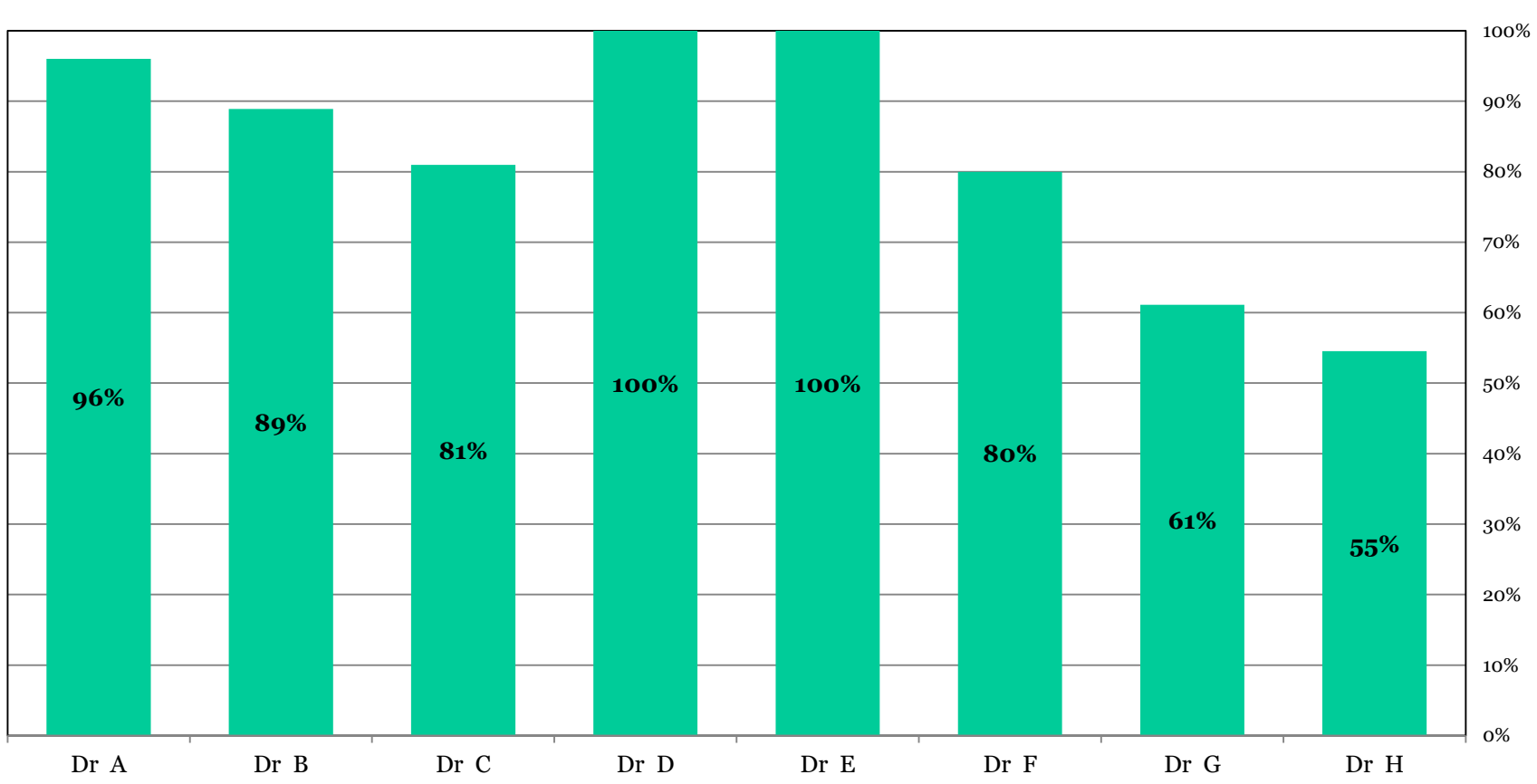
Aim – To increase the proportion of acute medical patients with select CMGs (as appropriate) discharged from St Thomas Elgin General Hospital seeing primary care provider within 7 days of discharge from ~23% to 30% by March 31, 2015

Aim – To increase the proportion of discharge summaries sent within 48 hours from St. Thomas hospital to primary care or community provider for acute medical patients from 41% to 80% by March 2015

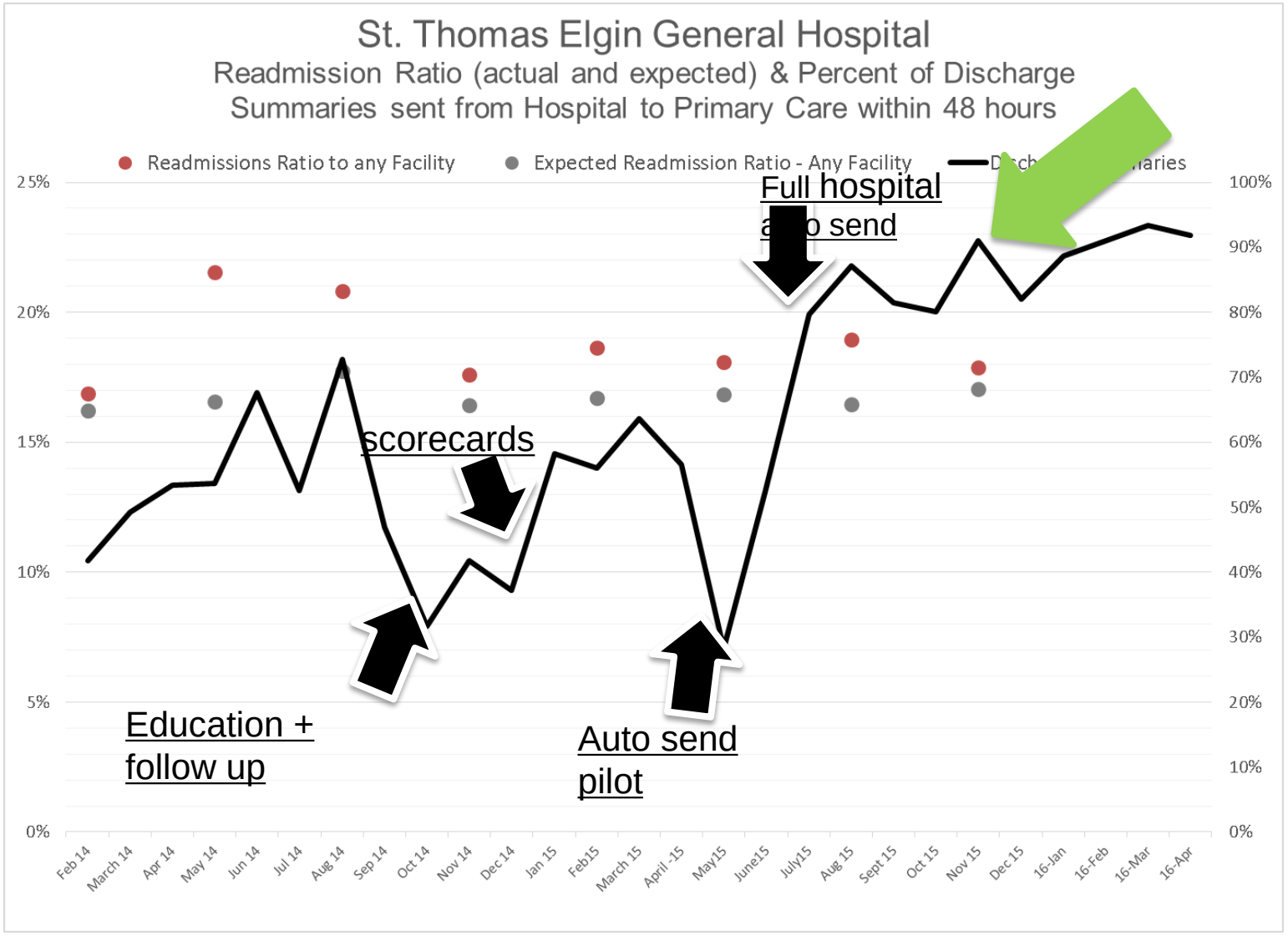


St.Thomas Elgin General Hospital

Clinical Associates Performance Scorecard
% of Discharge Dictated within 48hrs

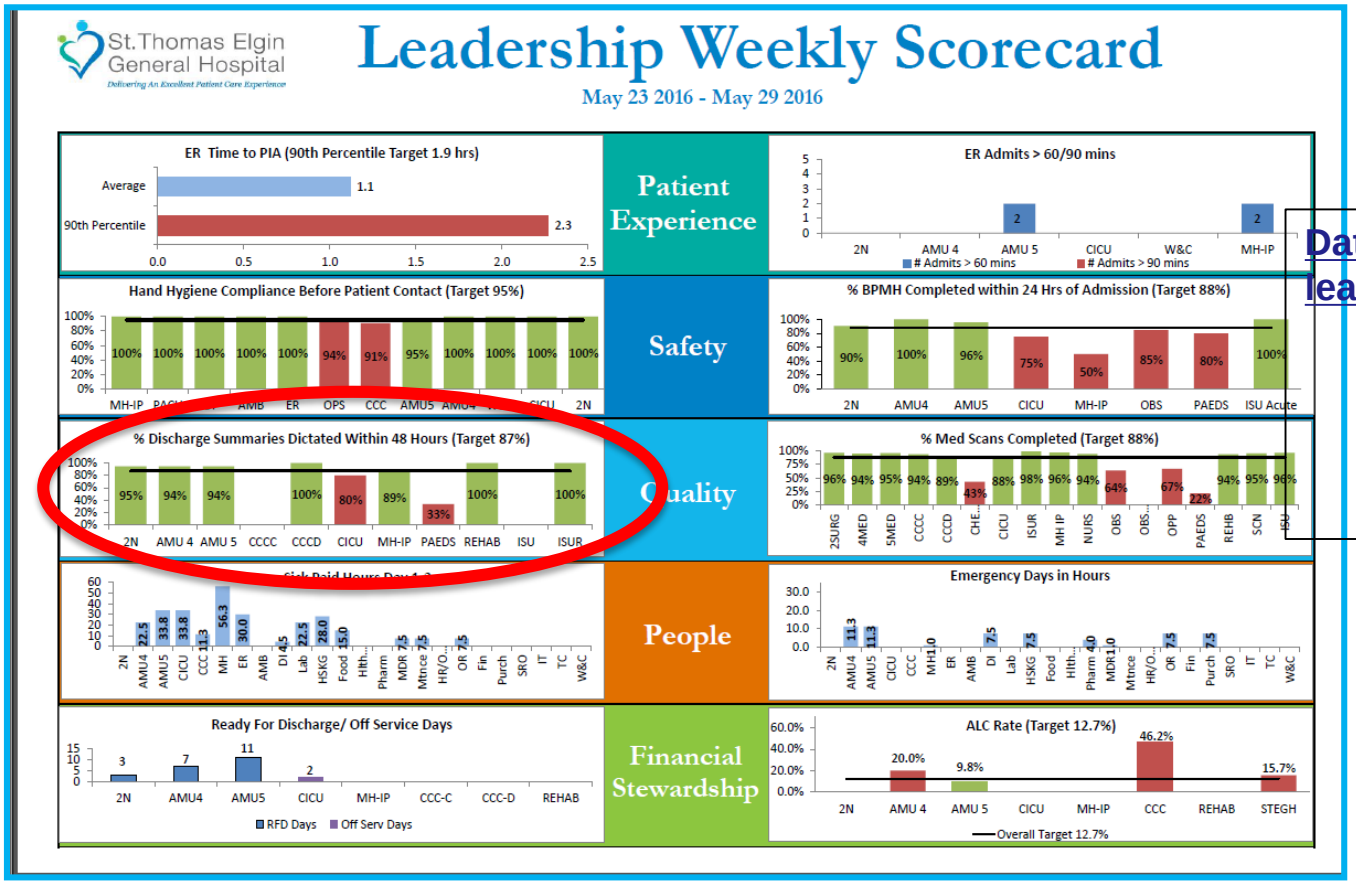


St.Thomas Elgin General Hospital



St.Thomas Elgin General Hospital

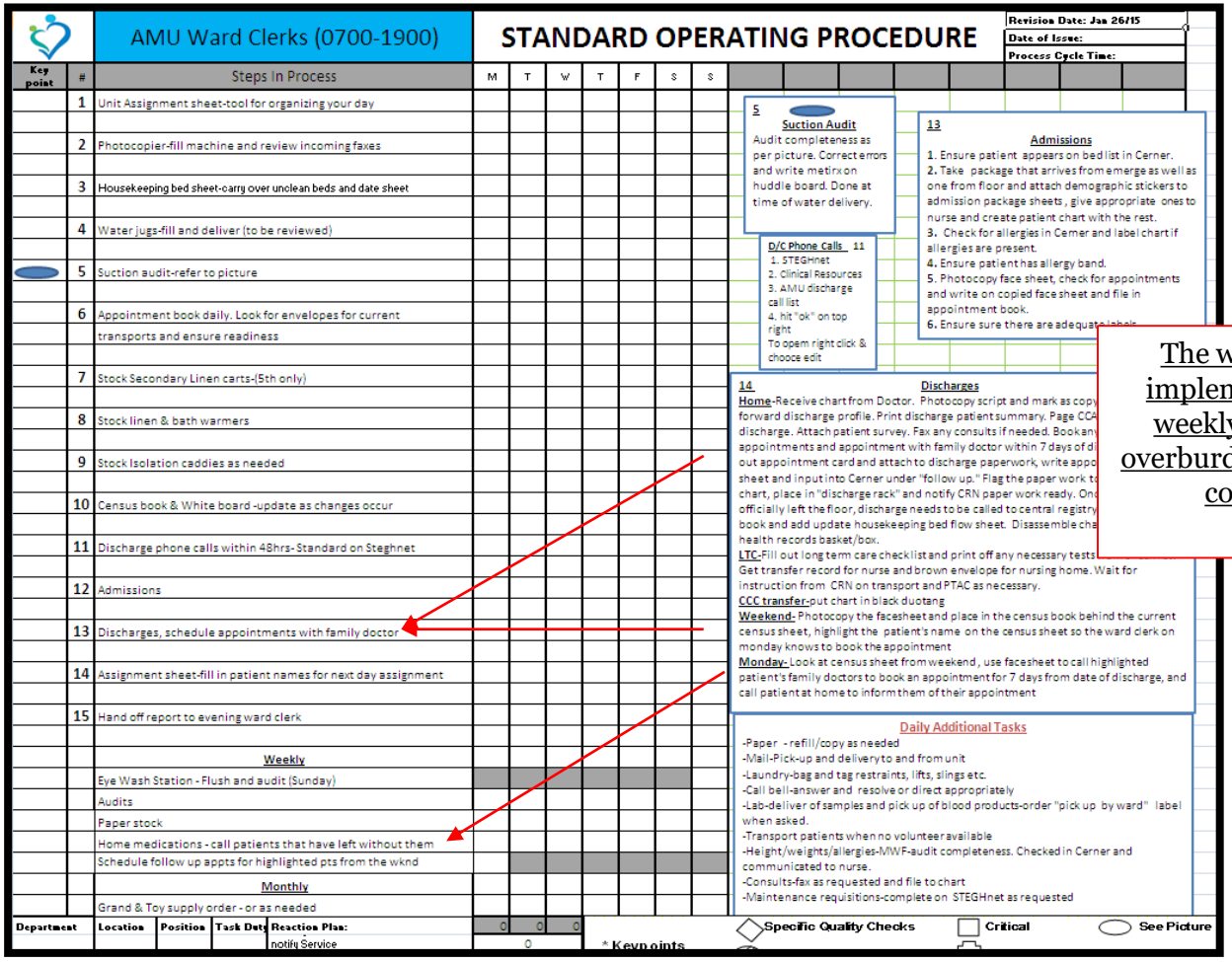
Sustain - Leadership Scorecard



[Data reviewed weekly at leadership huddle]

St.Thomas Elgin General Hospital

Standard Operating Procedure



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 Date	Reaction Plan:
				notify Service

0 0 0 0

* Key points

Specific Quality Checks | Critical | See Picture

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

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

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

14 Discharges
Home-Receive chart from Doctor. Photocopy script and mark as copy forward discharge profile. Print discharge patient summary. Page CCA discharge. Attach patient survey. Fax any consults if needed. Book any appointments and appointment with family doctor within 7 days of di out appointment card and attach to discharge paperwork, write appo sheet and input into Cerner under "follow up." Flag the paper work to chart, place in "discharge rack" and notify CRN paper work ready. Onc officially left the floor, discharge needs to be called to central registry book and add update housekeeping bed flow sheet. Disassemble cha health records basket/box.
LTC-Fill out long term care checklist and print off any necessary tests 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

The ward clerk standard work was already implemented, we just added a new daily and weekly task for them. Their workload is not overburdened so having these added tasks is not costly or effecting other daily work.

St.Thomas Elgin General Hospital

Snapshot Impact Summary

- Dictation turn around times reduced from ~24 hours to 5 hours *(mean)*
- Discharge summary process streamlined to eliminate report authentication – auto send!
- Overall **percent of discharge summaries sent from hospital to primary care within 48 hours** – was 41% (Aug. 2014) now sustaining **>+90% (since Oct. 2015)**
- **Improved patients having a scheduled following up appointment to ~82%**
- **Reduced variation in actual to expected readmission rate.**

St.Thomas Elgin General Hospital

Canadian Mental Health Association
Waterloo Wellington

Association canadienne pour la santé mentale
Waterloo Wellington

Intensive Geriatric Service Workers' Role and Partnerships that Achieve Successful Transitions in Care for Frail Seniors Living in the Community

Health Quality Ontario Webinar

November 16, 2016

Jane McKinnon Wilson

jmckinnon@cmhaww.ca

“Voice of the Client”

Successful Transitions

Designate a Person in the Community to Support Non-Clinical Needs in the Immediate Post-Hospital Period

Intensive Geriatric Service Worker

Key Roles: IGSWs

- Support successful transitions; Implement care plans: GEM Nurses, acute care health team or Specialized Geriatric Services; CCAC is a key partner in the development of the care plan – ED and Acute Care

- Provide timely intensive support, transition and follow-up with primary care, specialty care & community support services

- Consults and partners: “health links” team

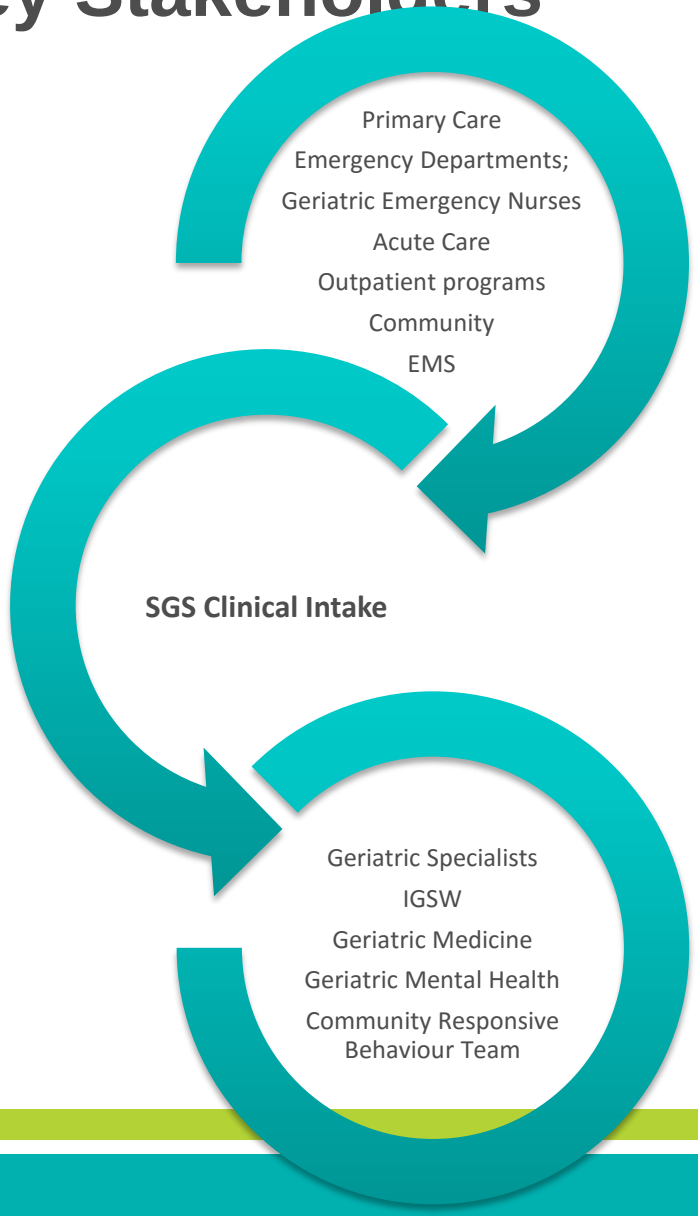
- Supports person-centered self-directed care (i.e., coach, educator; seniors and caregivers)

No Wait times; 72 hours

IGSW is a Core Service in the “Value Chain” – Key Stakeholders

IGSW delivers value to the seniors and his/her family and consistency throughout the ‘many’ transitions, within the health care “community”.

With the changing regional demographic, IGSW as part of the SSG will address the needs of an increasingly large population.

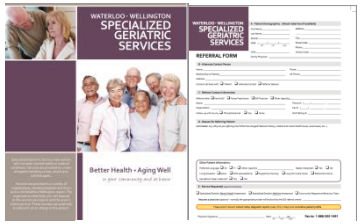


Seniors and Families

SGS Clinical Intake

Home | Primary Care | Memory Clinic | CSS | Hospital | CCAC | LTC

SGS



Memory Clinics

St. Joseph's | CCAC CASC

Cambridge Memorial Hospital | CCAC CASC

Canadian Mental Health Association Waterloo Wellington Dufferin

St. Mary's General Hospital

Grand River Hospital | CCAC CASC

Homewood Health Centre de Santé

Home Visit Appointment Slip

To guide and connect you with supports and services to help you in your home, you have an appointment with an Intensive Geriatric Service Worker:

IGSW Name:	Sylvia DeSchiffart
Date:	Wednesday, September 22, 2010
Time:	11:00 AM

If you are unable to keep the appointment, or have any questions please call:

(519) 772-8787 x 212 Waterloo - Community Support Connections

Your health information will be shared with your family doctor and other health partners involved in your care.
(PHIPA; IPC Brochure Circle of Care: Sharing Personal Health Information for Health-Care Purposes; Ipc.on.ca)

Close

Happy, Healthy, Safe

“I couldn’t believe it and everybody was so nice. I wish everybody could have the service I had.”

Transitions Across Systems and Geographies

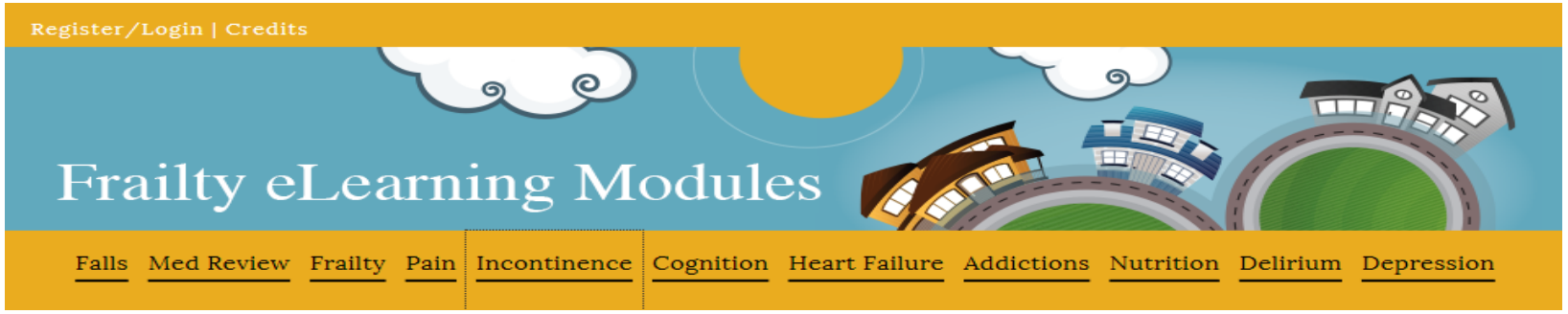
- ED - GEM Nurse – Acute Care – Home x 4
- Acute Care – Specialty Site – Outside LHIN
- Transitioned home:
    - IGSW
    - Primary Care
    - Specialized Geriatric Medicine
    - Community Responsive Behaviour Team - Addictions
    - Addictions Specialists - OTN

“It Takes a Village”

- The person
- IGSW - **Person Designated in the Community to Support Non-Clinical Needs in the Immediate Post-Hospital Period;**
- GEM Nurses
- Acute Care
- Primary Care
- Geriatric Medicine/ Geriatric Mental Health

Knowledge Care Team and Capacity Building – Core Competencies

Frailty e-modules



- http://www.regionalhealthprogramsww.com/frailtymodules/register/

Integration – ICC Framework

- Integrated Comprehensive Care (ICC) focussing on the person; smooth transitions of care across the system
-
- The IGSW has a key role in this model of care; they help the senior throughout each stage of their journey, across the continuum

- Integration is supported through the Waterloo Wellington Geriatric Services Network (WWGSN) – Sector representation and ‘voice of the senior’

http://www.sjhs.ca/integrated-comprehensive-care-project.aspx

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"Improving the seniors' transition from hospital to the community: a case for intensive geriatric service workers"

Acronyms

- CCAC = Community Care Access Centre
- IGSW = Intensive Geriatric Service Worker
- GEM Nurses= Geriatric Emergency Management Nurses
- SGS = Specialized Geriatric Services
- OTN = Ontario Telemedicine Network

IMPLEMENTING INNOVATIVE PRACTICES IN YOUR HEALTH LINK

Discussion;

Please submit questions to us via the "Question" box.

HEALTH LINK LEADERSHIP COMMUNITY OF PRACTICE;
Resources and Events

- Quality Rounds Ontario
  Monday November 21, 2016 from 12:00p.m. – 1:00 p.m.
  No limit to better: Leading quality improvement at St. Michael's Hospital

- Series of Webinars starting in January for the Health Link Community of Practice, invites to follow to members in near future.

- In the process of developing an online web presence for the Health Link Community of Practice. More information will follow

Learn more about upcoming program dates and deadlines to apply:

ideasontario.ca/programs/advanced-learning-program/

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