QUALITY STANDARD PLACEMAT FOR

Supporting High-Quality Transitions Between Hospitals and Long-Term Care Homes

Ontario Health

This document is a resource for health care providers and summarizes relevant components of the *Transitions Between Hospital and Home* quality standard that would apply to a transition to a long-term care home.

Information-Sharing and Assessment

Quality Statement (QS)* 1: Information-Sharing on Admission

When a person is admitted to hospital, their primary care and home and community care providers should:

- Receive real-time electronic notification of the patient's admission, diagnoses, and predicted discharge date
- Provide relevant information to the hospital admitting team, ideally within 3 business days

*The quality statements are provided in full on page 3.

QS 2: Comprehensive Assessment

- Initiate a comprehensive assessment of the patient's current and evolving health care and social support needs shortly after admission to hospital, and update it regularly
- Identify the patient's risk factors for a complex transition or readmission to help anticipate post-hospitalization health care or social support needs and establish an initial transition plan
- Share the assessment with the patient's primary care provider, home and community care providers, and relevant specialist physicians

Patient, Family, and Caregiver Involvement and Support

QS 3: Patient, Family, and Caregiver Involvement in Transition Planning

- Involve the patient, and their family and caregivers, in early transition planning, ensuring that decisions consider their needs and preferences, and are culturally appropriate

QS 4: Patient, Family, and Caregiver Education, Training, and Support

- Offer the patient, and their family and caregivers, information and support to help them manage their health care needs after their hospital stay
- Provide the health care team at the long-term care home with information on the patient's care plan, any equipment needed, and any education and/or training that staff may need to provide care for the patient
- Share this information verbally and in a written format

Preparing for Transitions

QS 5: Transition Plans

The transition plan should be:

- A written (printed or electronic) summary of the patient's hospital stay, their diagnoses, interventions performed, and recommended actions
- Developed and agreed upon in partnership with the patient, any involved caregivers, the hospital team, primary care and home and community care providers, and the receiving long-term care home before the patient leaves hospital
- Shared within 48 hours of discharge
- *Resource: Patient-Oriented Discharge Summary*

QS 6: Coordinated Transitions

A health care professional should be identified who will be responsible for:

- Timely transition planning, coordination, and communication, acting as single point of contact
- Ensuring the transfer of the transition plan to the long-term care home before the patient leaves hospital
- *Resource: Guiding Checklist: Supporting Transitions From Acute/Community Into Long-Term Care*

QS 7: Medication Review and Support

A medication review should:

- Be conducted by the hospital team on admission to hospital and before leaving hospital; this information should be shared with the long-term care home
- Be conducted at the long-term care home by the most responsible provider (e.g., most responsible physician or pharmacist) following transfer
- Include information on medication reconciliation, adherence, optimization, and use, as well as how to access medication at the long-term care home
- Consider the patient's ability to afford out-of-pocket medication costs and provide options for those unable to afford these costs
- *Resource: Best Possible Medication Discharge Plan*

QS 8: Coordinated Follow-Up Medical Care

- Before leaving hospital, the hospital team should arrange follow-up medical care with the patient's most responsible provider and/or relevant medical specialists
- Relevant medical information should be shared among providers
- Recommendations for follow-up care are included in the patient's transition plan

QS 10: Out-of-Pocket Costs and Limits of Funded Services

Here are some steps to take related to the costs of accommodation in long-term care homes:

- Before leaving hospital, the hospital team should assess the patient's ability to pay for long-term care, including costs associated with long-term care accommodation and meals (also known as a co-payment fee, which is a standard fee across all long-term care homes in Ontario)
- The hospital team should explain to the patient, and their family and caregivers, that in addition to the co-payment fee, the long-term care home may charge extra for optional services (e.g., hairdressing, transportation, and access to a telephone and internet)
- For those patients who cannot afford the basic co-payment fee, health care providers should assist with the application for financial help through the Long-Term Care Reduction Program
- *Resource: Paying for Long-Term Care*

Definitions

- **Health care providers:** regulated professionals as well as people in unregulated professions, such as administrative staff, behavioural support workers, personal support workers, recreational staff, spiritual care staff, and volunteers.
- **Home and community care providers:** health care providers based in the community, home care and community support service providers, care coordinators, staff at community service organizations, staff at community agencies for mental health and addiction services, managers or health care providers at long-term care homes or hospices, and community pharmacists.
- **Primary care provider:** a family physician (also called a primary care physician) or nurse practitioner.

Resources

- *Transitions Between Hospital and Home* quality standard and guide for patients and caregivers
  bit.ly/3fMMpgc
- Best Possible Medication Discharge Plan
  bit.ly/3V5K6F4
- Guiding Checklist: Supporting Transitions From Acute/Community Into Long-Term Care
  bit.ly/3SKDCtA
- Patient-Oriented Discharge Summary
  bit.ly/3fD9z8u

For Patients, Families, and Caregivers

- 5 Questions to Ask About Your Medications (questions people can ask to ensure they take medications safely)
  bit.ly/3yi1PPF
- TheHealthLine.ca (to find health and community services to support transitions)
  thehealthline.ca
- Paying for Long-Term Care (provides information on costs associated with long-term care)
  bit.ly/3Tmfgpy

Note: This resource can be used to support health care providers in the provision of care. It does not override the responsibility of health care providers to make decisions with patients, after considering each patient's unique circumstances. Grouping/directionality of statements may not be applicable for every patient, and clinical judgment should be used.

Transitions Between Hospital and Home QUALITY STATEMENTS

Quality Statement 1: Information-Sharing on Admission
When a person is admitted to hospital, the hospital shares information about the admission with their primary care and home and community care providers, as well as any relevant specialist physicians, soon after admission via real-time electronic notification. These providers in the community then share all relevant information with the admitting team in a timely manner.

Quality Statement 2: Comprehensive Assessment
People receive a comprehensive assessment of their current and evolving health care and social support needs. This assessment is started early upon admission, and updated regularly throughout the hospital stay, to inform the transition plan and optimize the transition process.

Quality Statement 3: Patient, Family, and Caregiver Involvement in Transition Planning
People transitioning from hospital to home are involved in transition planning and developing a written transition plan. If people consent to include them in their circle of care, family members and caregivers are also involved.

Quality Statement 4: Patient, Family, and Caregiver Education, Training, and Support
People transitioning from hospital to home, and their families and caregivers, have the information and support they need to manage their health care needs after the hospital stay. Before transitioning from hospital to home, they are offered education and training to manage their health care needs at home, including guidance on community-based resources, medications, and medical equipment.

Quality Statement 5: Transition Plans
People transitioning from hospital to home are given a written transition plan, developed by and agreed upon in partnership with the patient, any involved caregivers, the hospital team, and primary care and home and community care providers before leaving hospital. Transition plans are shared with the person's primary care and home and community care providers and any relevant specialist providers within 48 hours of discharge.

Quality Statement 6: Coordinated Transitions
People admitted to hospital have a named health care professional who is responsible for timely transition planning, coordination, and communication. Before people leave hospital, this person ensures an effective transfer of transition plans and information related to people's care.

Quality Statement 7: Medication Review and Support
People transitioning between hospital and home have medication reviews on admission, before returning home, and once they are home. These reviews include information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and options are provided for those unable to afford these costs.

Quality Statement 8: Coordinated Follow-Up Medical Care
People transitioning from hospital to home have follow-up medical care with their primary care provider and/or a medical specialist coordinated and booked before leaving hospital. People with no primary care provider are provided with assistance to find one.

Quality Statement 9: Appropriate and Timely Support for Home and Community Care
People transitioning from hospital to home are assessed for the type, amount, and appropriate timing of home care and community support services they and their caregivers need. When these services are needed, they are arranged before people leave hospital and are in place when they return home. *(Note: As this statement is not applicable to transfers to long-term care homes, it has not been included in the guidance on pages 1–2.)*

Quality Statement 10: Out-of-Pocket Costs and Limits of Funded Services
People transitioning from hospital to home have their ability to pay for any out-of-pocket health care costs considered by the health care team, and information and alternatives for unaffordable costs are included in transition plans. The health care team explains to people what publicly funded services are available to them and what services they will need to pay for.

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