

# Quality Standards

## Transitions From Hospital to Home

### Care for People of All Ages

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DRAFT

**Health Quality  
Ontario**

*Let's make our health system healthier*



**Ontario**

Health Quality Ontario

## **Summary**

This quality standard addresses care for people of all ages transitioning (moving) from hospital to home, commonly referred to as a “hospital discharge.” This includes people who have been admitted as inpatients to any type of hospital, including complex continuing care facilities and rehabilitation hospitals. “Home” is broadly defined as a person’s usual place of residence.

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## About Quality Standards

Health Quality Ontario, in collaboration with health care professionals, patients, residents, and caregivers across the province, is developing quality standards for Ontario.

Quality standards are concise sets of statements that will:

- Help patients, residents, families, and caregivers know what to ask for in their care
- Help health care professionals know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

The statements in this quality standard do not override the responsibility of health care professionals to make decisions with patients, after considering each patient's unique circumstances.

## How to Use Quality Standards

Quality standards inform clinicians and organizations about what high-quality health care looks like for aspects of care that have been deemed a priority for quality improvement in the province. They are based on the best available evidence.

Tools and resources to support clinicians and organizations in their quality improvement efforts accompany each quality standard. One of these resources is an inventory of indicator definitions to help clinicians and organizations assess the quality of care they are delivering, and to identify gaps in care and areas for improvement. These indicator definitions can be used to assess processes, structures, and outcomes. It is not mandatory to use or collect data when using a quality standard to improve care. The indicator definitions are provided to support quality improvement efforts; clinicians and organizations may choose indicators to measure based on local priorities and local data availability.

For more information on how to use quality standards, contact [qualitystandards@hqontario.ca](mailto:qualitystandards@hqontario.ca).

## About This Quality Standard

### Scope of This Quality Standard

This quality standard addresses care for people of all ages transitioning (moving) from hospital to home, commonly referred to as a “hospital discharge.” This includes people who have been admitted as inpatients to any type of hospital, including complex continuing care facilities and rehabilitation hospitals. “Home” is broadly defined as a person’s usual place of residence and may include personal residences, retirement residences, assisted-living facilities, long-term care facilities, and shelters. The scope of this quality standard includes all clinical populations, including groups that often face challenges with transitions (e.g., people with mental health, palliative, or end-of-life care needs), and applies to all health care providers.

### Terminology Used in This Quality Standard

“Caregiver” refers to a person who provides care and support in a nonprofessional capacity. Caregivers may be family members, friends, or anyone else identified by the person transitioning from hospital to home. Other terms commonly used to describe this role include “care partner,” “carer,” “family caregiver,” “informal caregiver,” and “primary caregiver.”

A patient’s “circle of care” includes those members of a health care team (from community and hospital) who have “implied consent to collect, use, and disclose a patient’s/client’s personal health information for the purpose of providing health care in specific circumstances,” as defined in Ontario’s privacy law, the *Personal Health Information Protection Act* of 2004.<sup>1</sup> This also includes family members and caregivers whom the patient consents to include in their circle of care.

A “community-based health care team” is a team of health care providers who care for people when they are outside the hospital. The team may include a primary care provider and a pharmacist, as well as any number of the following:

- Dietitian
- Home and community care coordinator
- Mental health service provider
- Nurse or nurse practitioner
- Personal support worker
- Social worker
- Specialist physician
- Therapist (e.g., occupational therapist, physiotherapist, speech-language pathologist)
- Volunteer (e.g., meal delivery, transportation services)
- Any other health care professional the patient considers part of the circle of care

A “primary care provider” is a family physician (also called a primary care physician) or nurse practitioner.

“Family” refers to family members, friends, or supportive people not necessarily related to the person transitioning from hospital to home. The person transitioning from hospital to home defines their family and who will be involved in their care.

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“Health care professionals” refers to regulated professionals, such as nurses, nurse practitioners, occupational therapists, pharmacists, physicians (family doctors, specialists), physiotherapists, psychologists, social workers, and speech-language pathologists. We use the term “health care providers” when we are also including 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” is broadly defined as the health care and social supports provided to a person in the home and community. These supports include home care services provided by provincial home and community care programs (e.g., case management, dietetics, nursing, occupational therapy, physiotherapy, social work, speech-language therapy), as well as by community support service agencies that operate outside of, but parallel to, the health system. Examples of services provided by such agencies include the following<sup>2</sup>:

- Adult day programs
- Caregiver relief and support
- Community dining
- Friendly visiting
- Homemaking and home help (e.g., home maintenance and repair)
- Meal delivery
- Supportive housing (i.e., long-term care and retirement homes)
- Transportation assistance
- Any other services that support people to live independently in their homes

“Hospital team” refers to all health care providers responsible for providing coordinated care for a person from hospital admission through their transition home. This includes, but is not limited to, the following:

- Dietitians
- Mental health service providers
- Nurses and nurse practitioners
- Occupational therapists
- Pharmacists
- Physicians
- Physiotherapists
- Psychologists
- Social workers
- Speech-language pathologists
- Volunteers

An “integrated care team” consists of family members, caregivers, and health care providers across organizations, sectors, and locations.<sup>3,4</sup> This team relies on partnerships and relationships among hospital teams, home and community care teams, long-term care teams, and individuals in other health and social organizations who operate outside of, but parallel to, the health system to connect care across hospitals and communities more effectively.<sup>5</sup>

### **Why This Quality Standard Is Needed**

Care transitions occur when patients transfer between different care settings (e.g., hospital, primary care, community care) and between different health care providers during the course of

an acute or chronic illness. Transitions are critical and vulnerable points in the provision of health care.<sup>6</sup> A transition from hospital to home is a complex, multiple-step process that requires integrated communication and coordination among the patient, their caregivers, the hospital team, and the health care providers involved in the patient's next destination for care (e.g., primary care, long-term care, home and community care).<sup>7</sup> The transition process is further complicated by the complexities of the health system, in which care is delivered by multiple providers with various levels of accountability.<sup>8</sup> As a result, there are many points at which communication and care processes can break down. These include, but are not limited to, the following<sup>9,10</sup>:

- Preparing family and caregivers for the person's return home
- Communicating the person's care plan to the health care providers taking over the person's care
- Medication reconciliation and post-discharge medication adherence
- Arranging for transportation and equipment needs at home
- Coordinating appropriate follow-up care (e.g., follow-up medical appointments, home and community care services)

When care transitions are not managed well, patients may suffer harm from errors and delays in care. These errors and delays can result in avoidable hospital admissions, emergency department costs, and increased health care costs; they can also negatively affect patient experience.<sup>6,8,9,11-18</sup> Some patients may experience emotional distress and worsening of symptoms, and family and caregivers may also experience distress.<sup>10,19,20</sup>

An international survey from 2017 of adults aged 55 years and older found that many Ontarians who had been admitted to hospital in the previous 2 years experienced good communication and coordination of care; many respondents reported receiving written information about what symptoms to watch for at home, knowing whom to contact if they had a question, and receiving arrangements for follow-up care.<sup>21</sup> Despite these findings, there are opportunities for improvement in Ontario to ensure that all patients, as well as their families and caregivers, receive the support and information they need for a successful and seamless transition from hospital to home. For example, in a 2017 Ontario survey, about 25% of respondents reported that their primary care providers were not aware of the care they had received in hospital after they were discharged.<sup>22</sup>

A 2012 Health Quality Ontario report also identified gaps in communication and opportunities for improvement in care transitions.<sup>23</sup> For example, only 59% of people discharged from hospital were aware of which danger signs to look out for at home, and only 52% knew when to resume their usual activities. Although 80% reported knowing how to take their medications, 36% did not know what side effects to watch for. In addition, the report found that follow-up care was not consistently arranged. In 2016, about one-third of people discharged from hospital for a mental health or addictions condition did not have a follow-up visit with a physician within 7 days of discharge.<sup>22</sup> Fewer than half of people hospitalized with serious diseases, such as heart failure (48%) and chronic obstructive pulmonary disease (38%), were found to have had follow-up visits with a doctor within 7 days of leaving hospital<sup>22</sup>; this is an important finding, given that about 20% of people with one of these chronic conditions are readmitted to hospital within 30 days after discharge.<sup>23</sup>

Recent studies from Ontario demonstrate that as many as 35% of patients do not have or adhere to scheduled post-discharge appointments for follow-up medical care.<sup>24,25</sup> Issues such

as mobility limitations, low health literacy, financial concerns, and a lack of social supports can cause inequitable access to care by preventing people from getting to their appointments; therefore, these issues need to be addressed before discharge.<sup>24</sup> In turn, lack of coordination and poor communication about possible barriers to follow-up care before discharge can lead to unnecessary emergency department visits and hospital readmissions. Further, information is not consistently transferred between health care providers; the Change Foundation reports that many community-based service providers regularly rely on patients and informal caregivers to pass on relevant information to other providers.<sup>26</sup> Addressing these gaps in information flow can help people stay safe at home and avoid unnecessary return visits to hospital.

A 2017 Health Quality Ontario report explored the complex issues involved in care coordination using data from an international survey of primary care doctors conducted in 2015. Results highlight the systemic barriers that family doctors often face when coordinating care for their patients in home and community care, which in turn affect the experiences of their patients and caregivers.<sup>27</sup> When compared with family doctors in other parts of Canada, as well as other countries, Ontario has one of the lowest reported percentages of family doctors communicating with home care and community team members. Less than a third (29%) of family doctors in Ontario say they, or other staff in their practice, routinely communicate with their patients' community case managers or home care providers about their patients' needs and services to be provided. Only 36% of Ontario family doctors say it's easy, or very easy, to coordinate their patients' care with social services or other community providers when needed. About 30% of Ontario family doctors say they sometimes, rarely, or never receive a notification when their patient is discharged from hospital, and just over half (54%) of family doctors report that it often takes many days to receive this information.

A 2017 report from the Ontario Patient Ombudsman highlights the complex process of planning for discharge and recognizes transitions as a common source of patients' complaints.<sup>28</sup> The report identifies several opportunities to improve the quality of patients' experiences as they prepare for discharge and transition between health care settings and states that the key to improvement is accurate, timely communication and engagement with patients and their caregivers in planning and in addressing barriers.<sup>28</sup> Patients and their families and caregivers are the constant in transitions and are thus crucial to any strategies that support safe and effective transitions.<sup>29</sup>

Some patients transitioning from hospital to home are particularly vulnerable and at increased risk of adverse transition outcomes, such as people with complex care needs, including children and older people with multiple comorbidities.<sup>30-33</sup> Those who are medically underserved, have low socioeconomic status,<sup>34</sup> or are members of specific populations (e.g., Indigenous Peoples, newcomers to Canada, refugees, and the homeless) face several barriers to care, including a lack of programs and self-management resources in preferred languages, as well as a lack of culturally safe care.<sup>35</sup> Some of these populations are also disproportionately affected by poverty and social isolation, which in turn can reduce the effectiveness of care transitions. These people may need access to additional resources and increased collaboration with community partners and social services to ensure their health care needs are met.

### *What Matters to Patients and Caregivers During Transitions From Hospital to Home*

Improving patient and caregiver experiences during transitions from hospital to home is a priority for Ontario's health system, but little research exists on what matters most to them. Therefore, to support the development of this quality standard, Health Quality Ontario partnered with health care and community organizations to conduct a province-wide consultation through



broad engagement with people with lived experience of transitions from hospital to home. We spoke with people who had been discharged home after an overnight admission in an Ontario hospital within the past 3 years; we also spoke with caregivers of people who had been hospitalized and discharged home. We asked them about the factors that affected their experiences when transitioning from hospital to home,<sup>10</sup> and we defined “home” as including long-term care, supportive housing, and shelters, in addition to personal residences.

A total of 1,113 people completed our online survey; 44% had been patients, and 56% had been caregivers. In addition, 71 people participated in one of eight group discussions. The individuals we heard from and spoke with are representative of the diversity of patients and caregivers living across Ontario.<sup>10</sup> Most (86%) reported being discharged to an apartment, house, or other community residence, while 6% were discharged to a long-term care home and 6% were discharged to a rehabilitation facility or chronic care hospital.

Researchers grouped input from participants in the survey and discussion groups into 52 unique concepts related to the transition process. These concepts covered the continuum of care from being in hospital to preparing for a successful discharge (i.e., discharge planning and process, timely services, and logistical support after discharge) and returning to the community (i.e., coordination of follow-up medical care, home care and medical care in the community, out-of-pocket costs, and the limitations of funded services). People most often reported challenges with home care in terms of the consistency, reliability, sufficiency, and timeliness of publicly funded services. Many relied on family, friends, private services, or charities to fill the gaps. The second most common theme related to challenges with the discharge process, including such factors as insufficient communication, a lack of patient and caregiver involvement in the process, and timing.

In a second phase of this research, a smaller number of participants answered two key questions:

1. Which issue would lower your confidence to care for yourself (for patients) or the patient (for caregivers)?
2. Which areas should be prioritized for improvement (as top priorities for the health system)?

The following concepts were rated most important for both questions; they are listed in order of priority to respondents. The top-rated concepts were fairly consistent across subgroups of patients and caregivers from different backgrounds and circumstances:

1. Not enough publicly funded home care services to meet the need
2. Home care support that is not in place when arriving home from hospital
3. Having to advocate to get enough home care
4. Not being involved in discharge planning
5. Once home, having no contact numbers for people to call if there is a problem
6. During discharge planning, the assumption by hospital staff that family and friends will provide care
7. Long waits for follow-up appointments with family doctors and specialists
8. Unclear or inconsistent communication about health status in preparation for going home

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Our engagement with people who have experienced transitions from hospital to home informed the development of this quality standard. Learning about people’s experiences helped us to know what topics we needed to address.

## Principles Underpinning This Quality Standard

This quality standard is underpinned by the principles of respect, equity, and equality.

People transitioning from hospital to home should receive services that are respectful of their rights and dignity and that promote shared decision-making and self-management throughout their transition. People transitioning from hospital to home, along with any involved family members and caregivers, should feel respected, listened to, and included throughout the transition process.

People transitioning from hospital to home should be provided services that are respectful of their gender, sexual orientation, socioeconomic status, housing, age, disability, and background (including self-identified cultural, linguistic, ethnic, and religious backgrounds). Equitable access to the health system includes access to culturally safe care. Language, a basic tool for communication, is an essential part of safe care and needs to be considered throughout a person’s health care journey. For example, services should be actively offered in French and other languages.

People transitioning from hospital to home should receive timely, appropriate care that is integrated across all sectors of the health system (e.g., acute [hospital] care, family practice and other primary care, specialist care, long-term care, and home and community care). Care should be provided by interprofessional teams working together and consulting with one another to plan transitions from hospital to home according to patient and caregiver needs over time. Interprofessional collaboration, shared decision-making, coordination of care, and continuity of care (including follow-up care) are hallmarks of this person-centred approach. Collaborative practice in health care “occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers, and communities to deliver the highest quality of care across settings.”<sup>36</sup>

Person-centred care aims to promote the health and well-being of the whole person, with the person and their goals guiding all care. Person-centred care during transitions from hospital to home includes developing an individualized transition care plan that considers individual preferences, attitudes, experiences, and outcomes of previous treatments. Person-centred care also involves family members and caregivers when they are involved in a person’s care; this is especially true for children and adolescents under the age of majority.

Care providers should be aware of the historical context of the lives of Indigenous Peoples throughout Canada and be sensitive to the impacts of intergenerational trauma and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities. This quality standard uses existing clinical practice guidelines developed by non-Indigenous groups, which might not include culturally relevant care or acknowledge traditional Indigenous beliefs and practices. Therefore, it is important for care to be adapted to ensure that it is culturally appropriate and safe for First Nations, Inuit, and Métis Peoples in Ontario.

A high-quality health system is one that provides good access, experiences, and outcomes for everyone in Ontario, no matter where they live, what they have, or who they are.

## Patient Guide

The patient guide on transitions from hospital to home can help patients and families have conversations with their health care provider. Inside, patients will find questions they may want to ask as they work together to make a plan for their care.

Clinicians and health services should make patient guides available in settings where people receive care.

## How Success Can Be Measured

The Transitions from Hospital to Home Quality Standard Advisory Committee identified a small number of overarching goals for this quality standard. These have been mapped to indicators that providers may want to monitor to assess the quality of care provincially and locally.

### *How Success Can Be Measured Provincially*

In this section, we list indicators that can be used to monitor the overall success of the standard provincially, given currently available data. If additional data sources are developed, other indicators could be added.

- Percentage of people discharged from hospital to home who received home care who report that their home care started when they needed it to
- Percentage of people discharged from hospital to home who report that when they left the hospital, they had a better understanding of their condition than when they entered
- Percentage of people discharged from hospital to home who visit the emergency department within 30 days after discharge

### *How Success Can Be Measured Locally*

Providers may want to monitor their own quality improvement efforts and assess the quality of care they provide to people transitioning from hospital to home. It may be possible to do this using their own clinical records, or they might need to collect additional data. We recommend the following indicators to measure the quality of care patients are receiving; these indicators cannot be measured provincially using currently available data sources:

- Percentage of people discharged from hospital to home who report feeling that they were involved in decisions about their transition planning as much as they wanted to be
- Percentage of people discharged from hospital whose primary informal caregiver reports being supported as a caregiver by health care providers
- Percentage of people discharged from hospital for whom discharge summaries are delivered to primary care providers within 48 hours after discharge from hospital

In addition to the overall measures of success, each quality statement within the standard is accompanied by one or more indicators. These statement-specific indicators are intended to guide the measurement of quality improvement efforts related to the implementation of the statement.

To assess the equitable delivery of care, the statement-specific indicators and the overall indicators can be stratified by patient socioeconomic and demographic characteristics, such as income, education, language, age, sex, and gender.

## Quality Statements in Brief

### **Quality Statement 1: Information-Sharing on Admission**

When people are admitted to hospital, the hospital notifies their primary care and home and community care providers soon after admission via real-time electronic notification. The community-based providers 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 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 medications and medical equipment.

### **Quality Statement 5: Transition Plans**

People transitioning from hospital to home are given a written transition plan (which can reside fully within the discharge summary), developed by and agreed upon in partnership with the patient, any involved caregivers, the hospital team, and the home and community care team, before leaving hospital. Transition plans are shared with primary care and home and community care 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 from hospital to 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.

*Draft—do not cite. Report is a work in progress and could change following public consultation.*

**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 services they and their caregivers need. These services are arranged before people leave hospital and are in place when they return home.

**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 assessed by the health care team, and alternatives for unaffordable costs are considered 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.

## Quality Statement 1: Information-Sharing on Admission

When people are admitted to hospital, the hospital notifies their primary care and home and community care providers soon after admission via real-time electronic notification. The community-based providers then share all relevant information with the admitting team in a timely manner.

### Background

Clear communication and information-sharing among community health care providers and hospital services support smooth transitions from hospital to home.<sup>37</sup> Primary care and home and community care providers are often not informed that their patients or clients have been admitted to hospital. Community-based health care providers should receive real-time electronic notification of patient admissions to hospital, as they have relevant information that can help the hospital team, the patient, and caregivers. Engagement with existing primary care providers; home and community care providers; managers of retirement residences, assisted-living facilities, and long-term care facilities; and other community service providers early in the hospital admission process means that patients and caregivers are not required to repeat the same information multiple times to different providers.<sup>37</sup> Further, clear communication among care providers ensures the onus of sharing important information is not put on the patient or caregivers. Clear communication among providers during the admission process can also improve people's experiences in hospital, as it ensures the admitting team is given a range of information about people's needs, wishes, and circumstances.

Consent to sharing relevant information on admission is implied within the person's circle of care.<sup>1</sup>

It is imperative that hospital- and community-based providers share information with each other. Community-based providers should be given contact information for the hospital team, and information should be able to be transferred electronically; for example, via electronic health records, email, or secure messaging.

**Sources:** National Institute for Health and Care Excellence, 2015<sup>37</sup> | Registered Nurses' Association of Ontario, 2014<sup>38</sup>

### Definitions Used Within This Quality Statement

#### **Home and community care providers**

This term includes health care providers based in the community, including home and community care providers; managers of retirement residences, assisted-living facilities, and long-term care facilities; care coordinators; and after-hours primary care providers. These providers are identified by the hospital staff in partnership with the patient, family, and caregivers as those who have key information that could assist with the patient's care in hospital and support their transition from hospital to home. (See also "community-based health care team" in the "Terminology Used in This Quality Standard" section.)

#### **Real-time electronic notification**

Primary care and home and community care providers should receive real-time, or near real-time, electronic notification of hospital admissions for their patients or clients.

### **All relevant information**

When transferring a patient from the community to the hospital or when notified of a patient's admission to hospital, primary care and home and community care providers should give the admitting team all relevant information.<sup>37</sup> This information could include, but is not limited to, the following:

- Cumulative patient profile (i.e., summary of the patient's medical conditions, medical history, current medications [including indication for use, dosage, frequency, and route of administration], allergies, family history, and social history)
- Existing care plans or individualized care plans (including specific care goals informed by the patient and their caregivers)
- Recent investigations
- The person's ability to communicate
- The person's linguistic background
- The person's cultural background
- Sociodemographic characteristics that may affect the person's health care needs
- Information about the person's needs and wishes
- Behavioural issues that may need to be addressed
- Named caregivers, next of kin, and any appointed powers of attorney
- Housing status
- Preferred places of care
- Advance care plans (i.e., plans about the person's wishes for future health and personal care should they become too ill and unable to communicate<sup>39</sup>)

In circumstances where patients are being transferred for acute concerns that are likely to be addressed quickly, much of the above information might not need to be conveyed.

### **Timely**

Community-based providers should provide relevant information to the admitting team within 1 business day if the person is admitted on a weekend or statutory holiday.

## **What This Quality Statement Means**

### **For Patients**

When you are admitted to the hospital, hospital staff should ask you:

- The name of your family doctor or nurse practitioner
- The name of any other health care providers you have outside the hospital, such as a home care nurse or therapist

The hospital should let these health care providers know that you have been admitted to the hospital and give them information about the care you receive while you are there.

Your family doctor or nurse practitioner and your home or community care provider should share any important information they have about your health with the hospital. This communication will help make sure you receive the best possible care while you are in the hospital and when you leave.

## **For Clinicians**

*Hospital-based providers on the admitting team:* Notify the patient’s primary care provider (or their delegate, as appropriate within their scope of practice) and any involved home and community care providers of the patient’s admission to hospital, their diagnosis, and their predicted discharge date via real-time electronic notification.

*Primary care providers and home and community care providers:* Share all available relevant information with the admitting team when you arrange for or are notified of a hospital admission for one of your patients or clients. Share information within 1 business day.

## **For Health Services**

Ensure hospitals have systems, processes, and resources in place to notify the patient’s primary care provider (or their delegate, as appropriate within their scope of practice) and any involved home and community care providers of the patient’s admission to hospital, their diagnosis, and their predicted discharge date via real-time electronic notification.<sup>40</sup> If the patient is not currently a client of home and community care but will need a referral to such services, the hospital should notify the relevant home and community care services as soon as this decision is made.

Ensure that systems, processes, and resources are in place to allow hospital teams and primary care and home and community care providers to share information with each other. Ensure that clear instructions and relevant contact information are provided to community-based providers regarding how to share information with the hospital (e.g., a portal for transferring relevant information from electronic health records, fax number).

## **Quality Indicators**

### *Process Indicator*

#### **Percentage of people discharged from hospital (or their caregivers) who report that there was always good communication about their care between their hospital and community-based health care providers**

- Denominator: total number of people discharged from hospital (or their caregivers)
- Numerator: number of people in the denominator who report that there was always good communication about their care between their hospital and community-based health care providers
- Exclusions: patients who respond that they do not know or do not remember
- Note: A validated survey question that can be used to inform local data collection is available in the Canadian Patient Experiences Survey<sup>41</sup>: “Do you feel that there was good communication about your care between doctors, nurses, and other hospital staff?” (Response options: “Never, Sometimes, Usually, Always”)
- Data source: local data collection via patient survey

### *Structural Indicator*

#### **Local availability of electronic health records**

- Data source: local data collection



## 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.

### Background

A comprehensive assessment of needs goes beyond the clinical examination and considers the current and evolving health care and social support needs of the whole person. It takes into account any physical, mental, or social challenges the person may face.<sup>42</sup> The assessment should be initiated early upon admission to hospital and should be developed by and shared with the patient's hospital- and community-based teams. This assessment helps to anticipate any post-hospitalization health care or social support needs and to establish an initial transition plan. If comprehensive assessments are not done upon admission, or if individual assessments are not used to inform transition plans, this can result in longer hospital admissions, unnecessary readmissions, and poorer patient experiences.<sup>38</sup>

Older people and people with complex care needs make up a substantial proportion of hospital admissions. Many have multiple chronic conditions that can lead to complex medical, functional, psychological, and social needs.<sup>30-33,43</sup> Delirium is also common among older people with complex care needs who are admitted to hospital but is often not fully resolved by discharge. For those leaving hospital with delirium, additional supports may be required upon their return home, if only for the short term. Vulnerable populations, including people with low socioeconomic status and those who are medically underserved, may also experience more adverse events after discharge from hospital.<sup>34</sup> Individualized comprehensive assessments help health care providers identify people who may be at risk, coordinate health and social support services for those who need them, and develop long-term plans to manage patients' transition needs.

**Sources:** National Institute for Health and Care Excellence, 2015<sup>37</sup> | Registered Nurses' Association of Ontario, 2014<sup>38</sup>

### Definitions Used Within This Quality Statement

#### Comprehensive assessment

A comprehensive assessment is an individualized assessment of a person's current and evolving health care and social support needs. It should be started early upon the person's admission to hospital, and updated regularly throughout the admission process, to inform the transition plan. A comprehensive assessment consists of, but is not limited to, the following:

- The person's presenting concerns, both health and social, as well as any caregiver concerns
- Current housing situation
- Current and evolving care requirements on admission
- Medication review and reconciliation on admission (see quality statement 7)
- Clinical functional status evaluation
- Cognitive and psychological status
- Assessment for substance misuse
- The person's ability to manage activities of daily living

- The person’s degree of health literacy
- A comprehensive geriatric assessment for older people with complex needs (i.e., one or more of the following: falls, immobility, delirium or dementia, polypharmacy, incontinence, end-of-life care)<sup>44</sup>
  - Older people are those aged 65 years and older, but younger people may also need a comprehensive geriatric assessment depending on their health, needs, and/or circumstances
  - The assessment should also consider additional supports that may be needed when the person returns home, even if such supports are needed only for the short term
- Identification of risk factors for a complex transition or readmission; this could include, but is not limited to, the following<sup>37</sup>:
  - Palliative care needs
  - Homelessness
  - Lack of suitable placement in a care home
  - Need for assessments for eligibility for health and social care funding
  - Reduced cognitive ability
  - Safeguarding issues (i.e., any circumstances in the person’s life that may put their personal safety at risk; for example, abuse or neglect)

Some health care teams use readmission risk assessment tools as part of a comprehensive assessment. While there is insufficient evidence to recommend this practice routinely, health care teams may find it useful to use such tools, particularly when the use of the tool can be automated (e.g., via the Hospital Admission Risk Prediction [HARP] tool<sup>45</sup> or the LACE index<sup>46,a</sup>).

- Names and contact information for caregivers and other people involved in the person’s circle of social support
- Advance care planning needs

### **Health care needs**

A person’s health care needs are the needs they have for the treatment, care, or aftercare they receive for a disease, illness, injury, or disability. These needs may be addressed through diet, medical care, nursing, occupational therapy, physiotherapy, social work, speech-language therapy, or mental health services.

### **Social support needs**

Social support needs arise when people live in complex social circumstances (e.g., complex family dynamics, living alone, low income, unstable housing), have complex health issues (e.g., cognitive impairment, mental health condition, or face insufficient caregiver availability or capacity). These needs may be met through community support services or housing and social services or via other funding sources.

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<sup>a</sup> The LACE index scoring tool assesses a person’s risk of readmission by looking at four factors: their length of hospital stay, the acuity of their condition upon admission, their comorbidities, and the number of times the person visited an emergency department in the previous 6 months. This tool is optional, and how best to use it in the real world remains unclear.

## **Transition plan**

A transition plan is a document that describes the coordination of care and support needs for a person's transition from hospital to home (see quality statement 5).

## **What This Quality Statement Means**

### **For Patients**

Shortly after you are admitted to the hospital, a health care professional should ask you about:

- Your health
- Your ability to function at home and at school or work
- Any other issues that affect your health

This is called a comprehensive assessment. The people taking care of you in the hospital will use this information to make sure you receive the best possible care while you are in the hospital and after you return home.

### **For Clinicians**

Initiate a comprehensive assessment (see definition) shortly after people are admitted to hospital, and update the assessment throughout the hospital stay. Complete a comprehensive geriatric assessment for older people with complex needs and for people younger than 65 years of age as appropriate (i.e., depending on their health, needs, and/or circumstances). Identify people who are at risk for a complex transition (e.g., older people, people with multiple comorbidities, people with complex social circumstances), coordinate health and social support services for those who need them, and develop long-term plans to manage people's transition needs. Work with community-based interprofessional teams to identify factors that could prevent a safe, timely transition from hospital to home.

### **For Health Services**

Ensure hospitals have systems, processes, and resources in place to initiate a comprehensive assessment early upon a person's admission to hospital and to update the assessment throughout the admission process.

## **Quality Indicators**

### *Process Indicator*

#### **Percentage of people discharged from hospital to home whose comprehensive assessment was updated regularly throughout their hospital stay**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator whose comprehensive assessment was updated regularly throughout their hospital stay
- Data source: local data collection

## 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.

### Background

Patients, family members, and caregivers all play an essential role in transition planning. They can provide information about the patient's life and needs, including relevant circumstances beyond the patient's medical condition and physical needs.<sup>37</sup> When patients return home, family members and caregivers are often involved in providing care (e.g., wound care, giving medications) and helping with activities of daily living (e.g., meal preparation, transportation to follow-up appointments), watching for worrisome signs and symptoms, and advocating for the patient. It is therefore important that they are involved early in discussions about the transition plan to ensure that decisions respect the patients' values, preferences, and expressed needs, as well as those of their caregivers.<sup>47</sup> However, for family members and caregivers to be involved in transition planning, the patient must consent to include them in their circle of care. It is also important to recognize when a patient does not have family members or caregivers involved in their care and to plan for additional support following the patient's transition if needed.

It is important to consider that family members and caregivers can experience strain, anxiety, and stress in their role supporting patients.<sup>20,37</sup> Health care professionals sometimes assume that family members or caregivers will provide support to the patient following their transition from hospital to home without ensuring their capacity to do so.<sup>10,37</sup> Health care professionals should thus consider the capacity of family members and caregivers to meet the patient's needs upon discharge and offer additional resources or respite needs when required.<sup>37</sup> Caregivers are also sometimes young; it is important that health care professionals respect the role of these individuals and include them in all aspects of transition decision-making.

The involvement of patients, family members, and caregivers in transition planning should be culturally appropriate, and efforts should be made to address the needs of all those involved in transition planning (e.g., by assisting people with physical, sensory, or learning disabilities or by providing translations for those who do not speak or read English) so that they can effectively contribute to the plan. When needed, an interpreter or advocate should be made available.

**Sources:** Concept Mapping Patient Experience Research<sup>10</sup> | National Institute for Health and Care Excellence, 2015<sup>37</sup>

### What This Quality Statement Means

#### For Patients

You should be involved in all decisions about your transition from hospital to home. This makes sure that your wishes, needs, and preferences are considered. If you want them to be involved, your family and caregivers can also be part of these decisions.

### **For Clinicians**

Ensure that patients are involved in transition planning. If patients consent to their involvement, family members and caregivers should also be involved, as they are important sources of information about patients' needs. Consider the willingness and capacity of family members and caregivers to provide support at home to ensure the patient's support needs will be met once they return home, and identify any needs for caregiver respite. For patients without family members or caregivers involved in their care, make appropriate arrangements to ensure patients' needs will be met once they return home.

### **For Health Services**

Ensure hospitals have systems, processes, and resources in place to enable the involvement of the patient, family, and caregivers in transitions planning.

## **Quality Indicators**

### *Process Indicators*

#### **Percentage of people discharged from hospital to home who report feeling that they were involved in decisions about their transition planning as much as they wanted to be**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report feeling they were involved in decisions about their transition planning as much as they wanted to be
- Data source: local data collection via patient survey
- Exclusions: patients who respond that they did not want to be involved in their transition planning

#### **Percentage of people discharged from hospital to home who report feeling that their family and caregivers were involved in decisions about their transition planning as much as they wanted to be**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report feeling that their family or caregivers were involved in decisions about their transition planning as much as they wanted to be
- Data source: local data collection via patient/caregiver survey
- Note: A similar survey question can be found in the Canadian Patient Experiences Survey<sup>41</sup>: "Were your family or friends involved as much as you wanted in decisions about your care and treatment?" (Response options: "Never, Sometimes, Usually, Always, I did not want them to be involved, I did not have family or friends to be involved")
- Exclusions: patients who respond "I did not want them to be involved" or "I did not have family or friends to be involved"

#### **Percentage of people discharged from hospital to home for whom a caregiver reports feeling prepared for the role of caregiving**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator for whom a caregiver reports feeling prepared for the role of caregiving

*Draft—do not cite. Report is a work in progress and could change following public consultation.*

- Data source: local data collection via patient survey
- Note: A validated survey question that can be used to inform local data collection is available in the Home and Community Care Caregiver Experience Survey (still in development)<sup>48</sup>: “Do you feel prepared for the role of caregiving? (Response options: “Very well prepared, Somewhat well prepared, Neither well prepared nor poorly prepared, Somewhat poorly prepared, Very poorly prepared, Do not know/do not remember”)

## 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 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 medications and medical equipment.

### Background

Hospitalization is stressful for patients, families, and caregivers, and the move from hospital to home can be a time of heightened stress, as many important care instructions are given to them at this time.<sup>49</sup>

It is important to patients and their families and caregivers that they know exactly what to do when they transition from hospital to home (e.g., what medications to take and when, how to manage any medical equipment that is needed) and whom to contact in the event that questions or unexpected symptoms arise.<sup>10</sup> If a patient is transitioning to a retirement residence, assisted-living facility, or long-term care facility, the receiving health care team should also be given this information. Receiving clear instructions, contact information for a health care professional, and information about relevant community resources at the time of transition can ease anxiety and provide comfort to patients, families, and caregivers. This information can also help with recovery and avoid potential harm.<sup>10,49</sup>

Building patient and caregiver capacity to manage patient care at home should begin during the patient's hospital stay and continue in the community when they transition home.<sup>37</sup> The information and training provided should be tailored to the individual needs of the patient, their perception of their health condition, their cognitive ability, and their stage of readiness to care for themselves, as well as to the needs of family members and caregivers and their willingness and capacity to provide care for the patient. Information and training should be culturally appropriate and accessible to all involved (e.g., by accommodating physical, sensory, or learning disabilities or by providing translations for those who do not speak or read English). When needed, an interpreter or advocate should be made available. Patients without family or caregiver support should be identified, and plans for additional support should be made if needed.

**Sources:** Concept Mapping Patient Experience Research<sup>10</sup> | National Institute for Health and Care Excellence, 2015<sup>37</sup> | Registered Nurses' Association of Ontario, 2014<sup>38</sup>

### Definitions Used Within This Quality Statement

#### **Education, training, and support**

Education should be tailored to the individual needs of the patient or caregiver and provided in a variety of formats, including verbally (through face-to-face meetings or phone calls), written, and/or electronic, using plain language and visual tools. Training may be hands-on (e.g., coaching on how to use medical equipment, administer medication, change bandages or dressings, provide enteral feedings, or transfer the patient from one position to another). The “teach-back” method, in which the trainer asks the trainee to explain what they have been taught, can be used to confirm patient or caregiver understanding. This practical support and advice may be provided in hospital and continue in the community once the person is home.

*Draft—do not cite. Report is a work in progress and could change following public consultation.*

Important information and care instructions may be included, such as the following:

- A list of medications and how to use them (see quality statement 7)
- Self-care instructions for both the patient and caregiver
- Contact information for a health care professional who can provide answers to questions
- Warning signs and symptoms to watch out for, including which signs and symptoms should prompt a call to a health care professional and which require a visit to the emergency department
- Changes to their routine when they return home, including changes to diet and physical activity
- Follow-up appointments, including relevant contact information, location, date, time, and confirmation of bookings or whom to call if appointments are needed but have not yet been scheduled
- Information regarding where patients and caregivers can find more information and resources to support them

## What This Quality Statement Means

### For Patients and Caregivers

Your health care team should help you learn how to manage your care at home, including how to take medications and use medical equipment. Ask your care team for written instructions.

Here are some important things you should know:

- What medications you need, how to take them, and what they're for
- How you might feel and what activities you can do once you're at home again
- What symptoms mean you should call a health care professional or go to the emergency department
- Any changes you need to make to your daily routine
- What follow-up appointments have been scheduled for you
- Where to go for more information or resources to support you

Your care team can share this information verbally or in a written format. You may also get hands-on training for things like how to take medications, change bandages, or use medical equipment.

### For Clinicians

Provide education and training to patients and caregivers that will allow them to care for themselves or the people they are supporting effectively at home. This information and training should be tailored to their individual needs.

Ensure that a member of the hospital team is made responsible for providing the patient, family, and caregivers with information and support to allow for a successful transition home.

### For Health Services

Ensure hospitals have systems, processes, and resources in place to provide education, training, and support in response to the individual needs of patients transitioning from hospital to home, as well as those of their families and caregivers.



## Quality Indicators

### Process Indicators

#### **Percentage of people discharged from hospital to home (and their caregivers) who report having received enough information from hospital staff about what to do if they were worried about their health condition or treatment after leaving the hospital**

- Denominator: total number of people discharged from hospital to home (and their caregivers)
- Numerator: number of people in the denominator who reported that they received enough information from hospital staff about what to do if they were worried about their health condition or treatment after leaving the hospital
- Data source: local data collection via patient survey
- Note: A validated survey question that can be used to inform local data collection is available in the Canadian Patient Experiences Survey<sup>41</sup>: “Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?” (Response options: “Not at all, Partly, Quite a bit, Completely”)

#### **Percentage of people discharged from hospital to home who report feeling they had the support and services they needed to help them manage their health condition at home after leaving the hospital**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report feeling they had the support and services they needed to help them manage their health condition at home after leaving the hospital
- Data source: local data collection via patient survey
- Note: A validated survey question that can be used to inform local data collection is available in the Commonwealth Fund International Health Policy Survey<sup>50</sup>: “After you left the hospital, did you feel that you had the support and services you needed to help you manage your health condition at home?” (Response options: “Yes, No, I did not need support to manage my health, Not sure, Decline to answer”)

#### **Percentage of people discharged from hospital to home who report knowing whom to contact if they had a question about their health condition or treatment**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report knowing whom to contact if they had a question about their health condition or treatment
- Data source: local data collection via patient survey
- Note: A validated survey question that can be used to inform local data collection is available in the Home and Community Care Client Experience Survey (still in development)<sup>48</sup>: “When you left the hospital, did you know whom to contact if you had a question about your condition or treatment?” (Response options: “Yes, No, Do not know / Do not remember”)

## Quality Statement 5: Transition Plans

People transitioning from hospital to home are given a written transition plan (which can reside fully within the discharge summary), developed by and agreed upon in partnership with the patient, any involved caregivers, the hospital team, and the home and community care team, before leaving hospital. Transition plans are shared with primary care and home and community care providers within 48 hours of discharge.

### Background

Transitions from hospital to home can be complicated, as they involve many health care providers across several settings (e.g., community, hospital, long-term care). Patients and caregivers report that communication is key to effective transition planning and that having enough time with their health care providers to ask questions and actively participate in the transition process is especially important.<sup>10</sup> A transition plan helps ensure that a transition from hospital to home is well coordinated and meets the patient's needs, as well as the needs of the patient's caregivers.<sup>37</sup>

The transition plan can reside fully within a discharge summary, which is sent to the person's primary care provider and home and community care providers on discharge. Alternatively, the transition plan can be a separate document that accompanies the discharge summary. Consent for sharing the transition plan is implied within the person's circle of care.<sup>1</sup> Transition plans should also be shared with the person (e.g., via a patient-oriented discharge summary<sup>51</sup>).

Communication about discharge timing and logistics (e.g., when and how the person is transported home, any costs involved, geographical distance, the person's physical ability to get in and out of a vehicle) should also be included in the transition plan. These factors can be especially important for people with low socioeconomic status, people who live alone but need help to function effectively, and people who have to travel a substantial distance to return home.<sup>10,34</sup> If a person is homeless, the transition plan should include guidance on housing and social service needs.<sup>37</sup>

Barriers to communication (e.g., learning disabilities; cognitive impairments; physical, sight, speech, or hearing impairments; difficulties with reading, understanding, or speaking English) can hinder a person's understanding of their transition from hospital to home and how they can be involved in transition planning.<sup>35</sup> Where appropriate, transition plans should include accommodations to overcome these barriers and ensure people transitioning from hospital to home and their caregivers are involved in the transition decision-making process. Support for people with communication difficulties can include advocacy services.<sup>44</sup>

**Sources:** National Institute for Health and Care Excellence, 2015<sup>37</sup> | Registered Nurses' Association of Ontario, 2014<sup>38</sup>

### Definitions Used Within This Quality Statement

#### Transition plan

A transition plan<sup>40,44</sup> is a written (printed or electronic) document summarizing the person's hospital stay, their diagnosis, interventions performed, and recommended actions (e.g., coordination of care and support for transition from hospital to home). A transition plan is a working document for the interprofessional teams involved in the person's care and should include details about the following:

- The person’s health condition
- The person’s social and emotional well-being
- The person’s ability to accomplish activities of daily living
- A complete list of the person’s medications, including any changes made to medications during their hospital stay; this includes information about dosage, when to take medications, and what each medication is for (see quality statement 7)
- Contact information, including a phone number, for a health care professional for patients and caregivers to call if there are any problems once the patient is home again
- Arrangements for follow-up medical care (see quality statement 8)
- Arrangements for continuing home and community care support needs
- Arrangements for continuing health support needs
- Other useful community and voluntary services
- Arrangements for transportation home
- Arrangements for needed medical equipment and home modifications to be in place at the time of discharge
- Information about the person’s health care coverage and ability to pay for any out-of-pocket health care costs (see quality statement 10)

The transition plan should be shared with the person and all health care providers involved in the person’s ongoing care and support. If the person consents, the plan should also be shared with all involved family members and caregivers. All information in the plan, including explanations about medications, should be provided in a format that is easy for the person and their caregivers to understand (e.g., both verbally and written, with written material provided in plain language and translated as necessary).<sup>37</sup>

## What This Quality Statement Means

### For Patients

Your health care providers should include you in decisions about your transition from hospital to home. If you agree, your family and caregivers should also be involved. Your care team should create a written “transition plan” for you that explains everything you need to know about leaving the hospital and your care at home, including:

- How you will be transported home
- What medications you should take, how to take them, and what they’re for
- How to take care of yourself once you are at home

You should get a written copy of your transition plan before you leave the hospital. If you agree, your family and caregivers should also get a written copy of your transition plan. The plan should be easy to read and understand, and your care team should offer to explain it to you.

### For Clinicians

Upon a person’s discharge, alert the person’s primary care providers and home and community care providers of the discharge and share with them the person’s transition plan. Give the person a written copy of their transition plan or discharge summary before the person leaves hospital.

*Draft—do not cite. Report is a work in progress and could change following public consultation.*

Use standardized documentation tools to ensure a timely (i.e., within 48 hours of discharge), succinct, and clear exchange of the transition plan upon discharge.<sup>38</sup>

### **For Health Services**

Ensure hospitals have systems, processes, and resources in place to give people transitioning from hospital to home a written copy of their transition plan before leaving hospital.

Ensure hospitals have systems, processes, and resources in place for standardized documentation and communication strategies (e.g., electronic portal, fax) to allow for timely (within 48 hours of discharge), clear communication of the transition plan with primary care providers and home and community care providers.<sup>38,40</sup>

## **Quality Indicators**

### *Process Indicators*

#### **Percentage of people discharged from hospital to home who were given a written transition plan before leaving hospital**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who were given a written transition plan before leaving hospital
- Data source: local data collection
- Note: A validated survey question that can be used to inform local data collection is available in the Commonwealth Fund International Health Policy Survey<sup>50</sup>: “When you left the hospital, did you receive written information on what to do when you returned home and what symptoms to watch for?” (Response options: “Yes, No, Not sure, Decline to answer”)

#### **Percentage of people discharged from hospital to home with a transition plan (and their caregivers) who report feeling involved in the development of their transition plan**

- Denominator: total number of people discharged from hospital to home with a transition plan (and their caregivers)
- Numerator: number of people in the denominator who report feeling involved in the development of their transition plan
- Data source: local data collection via patient survey

#### **Percentage of people discharged from hospital who have a primary care provider, for whom discharge summaries are sent to their primary care providers within 48 hours after discharge (electronically or by fax)**

- Denominator: total number of people discharged from hospital who have a primary care provider
- Numerator: number of people in the denominator for whom discharge summaries are sent to their primary care providers within 48 hours after discharge (electronically or by fax)
- Data source: local data collection
- Note: This is an indicator for quality improvement plans in 2019/20. The current performance reporting period is the most recent 3-month period

*Draft—do not cite. Report is a work in progress and could change following public consultation.*

**Percentage of people discharged from hospital who receive home and community care, for whom discharge summaries are sent to their home and community care providers within 48 hours after discharge (electronically or by fax)**

- Denominator: total number of people discharged from hospital who receive home and community care
- Numerator: number of people in the denominator for whom discharge summaries are sent to their home and community care providers within 48 hours after discharge (electronically or by fax)
- Data source: local data collection

## 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.

### Background

Poor coordination and communication during a person's transition from hospital to home can be stressful for patients, as well as their families and caregivers, and can lead to poorer outcomes.<sup>37</sup> Having a health care professional in a designated discharge (or care transition) coordinator position has been shown to have a positive effect on hospital discharge processes and outcomes<sup>37,52</sup> and gives a better overall experience for patients and caregivers.<sup>53</sup> Patients and caregivers often want to ask their health care professionals about the transition from hospital to home<sup>10</sup>; having a named individual responsible for the transition process can help ensure that someone is always available to answer these questions.

For people with more complex care needs, all members of the hospital- and community-based interprofessional teams should be involved in transition planning and coordination. However, clearly naming a member of the integrated care team as a single point of contact for transition planning and coordination can make the transition smoother for patients and their families and caregivers.<sup>37</sup> In some instances, this person is the patient's most responsible physician or primary physician, a nurse practitioner, a nurse, a social worker, or another health care professional; in other instances, this person may have a job title such as "transitions care coordinator" or "discharge coordinator." This person should be selected based on the patient's care and support needs.<sup>37</sup>

**Sources:** National Institute for Health and Care Excellence, 2015<sup>37</sup> | Registered Nurses' Association of Ontario, 2014<sup>38</sup>

### Definitions Used Within This Quality Statement

#### Transition planning

Transition planning involves establishing a set of actions designed to ensure effective coordination and continuity of health care as people transition from hospital to home.<sup>31</sup>

### What This Quality Statement Means

#### For Patients

When you are admitted to the hospital, a health care professional should identify the person who's planning your transition home. This person will work with you and your family and caregivers throughout your hospital stay to make sure you know what will happen and what you need to do when you return home.

#### For Clinicians

Ensure a person is named to be responsible for coordinating patient transitions from hospital to home, and involve this person in transition-related decisions.

## **For Health Services**

Ensure hospitals have systems, processes, and resources in place so that patients, families, and caregivers have a named contact responsible for timely transition planning, coordination, and communication.

## **Quality Indicators**

### *Process Indicators*

#### **Percentage of people discharged from hospital to home who had a named health care professional responsible for timely transition planning, coordination, and communication while they were in hospital**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who had a named health care professional responsible for timely transition planning, coordination, and communication while they were in hospital
- Data source: local data collection

#### **Percentage of people discharged from hospital to home (or their caregivers) who report knowing whom to contact if they had questions about their transition from hospital to home while they were in hospital**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator (or their caregivers) who report knowing whom to contact if they had questions about their transition from hospital to home while they were in hospital
- Data source: local data collection via patient survey

### *Structural Indicator*

#### **Local availability of systems that provide patients, families, and caregivers a named contact responsible for timely transition planning, coordination, and communication**

- Data source: local data collection



## Quality Statement 7: Medication Review and Support

People transitioning from hospital to 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.

### Background

Transitions from hospital to home often involve changes to patients' medications. It is important to patients and their families and caregivers that they have a review of their medications with a health care professional before transitioning home.<sup>10</sup> Also crucial to a successful transition are the following<sup>10</sup>:

- Ensuring patients and caregivers are confident in their ability to manage medication regimens (their routine for taking medication)
- Assessing people's ability to afford medications and providing options for those unable to afford these costs (such as the Trillium Drug Program) and support applying for help, if needed
- Ensuring patients and caregivers know how to manage pain

People admitted to hospital should have a medication review (that includes reconciliation, adherence, and optimization) performed by their hospital pharmacist, most responsible physician, and/or nurse or nurse practitioner on admission and at discharge, and again by their most responsible community-based health care professional (e.g., their primary care provider, a community pharmacist, or a home care nurse) when they return home. Patients and caregivers (as appropriate) should be actively involved in medication reviews to ensure they are aware of all aspects of the patient's medication regimen. A medication review and reconciliation should also be part of the patient's transition plan (see quality statement 5) and carefully communicated to relevant community-based providers to support a safe and effective transition from hospital to home.<sup>38,40,54</sup>

**Sources:** Concept Mapping Patient Experience Research<sup>10</sup> | National Institute for Health and Care Excellence, 2015<sup>37</sup> | Registered Nurses' Association of Ontario, 2014<sup>38</sup>

### Definitions Used Within This Quality Statement

#### Medication review

A medication review is a structured, critical examination of a person's medications. The aim is for the health care professional and the patient to agree on the treatment plan, ensure the medication is being used effectively, minimize medication-related problems, and reduce waste.<sup>37</sup> A medication review includes medication reconciliation, adherence, and optimization.

#### Medication reconciliation

Medication reconciliation is a process in which health care professionals work with patients and caregivers to accurately identify all of a patient's current medications—including their names, dosages, and frequency of administration—so that this information can be accurately communicated to relevant care providers throughout the patient's transition from hospital to



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home. It is important to capture any medications that have been added, changed, or discontinued to ensure accuracy.<sup>37</sup>

### **Medication adherence**

Medication adherence is the extent to which a person follows their medication regimen; that is, how much a person uses their medications in the way they have agreed upon with their health care professionals. Nonadherence may limit the benefits of a medication, resulting in a lack of improvement or a deterioration in health. Nonadherence may be intentional or unintentional (e.g., as a result of poor recall or difficulties in understanding the medication regimen, problems taking the medications, an inability to pay for medications, or simply forgetting to take one's medications).<sup>37</sup>

### **Medication optimization**

Medication optimization means taking an individualized approach to a patient's medications, with the patient, to maximize benefit and minimize harm. It addresses both prescription and nonprescription medications to ensure that all are:

- Indicated (i.e., have a reason for use)
- Effective (i.e., doing what we expect them to)
- Safe (i.e., the benefits of use exceed the risks)
- Convenient (i.e., the patient can adhere to them; this includes paying for them and taking them as intended)

## **What This Quality Statement Means**

### **For Patients**

When you arrive at the hospital, a health care professional should:

- Ask you and your caregivers what medications you are taking

Before you leave the hospital, they should:

- Talk with you again in case any changes have been made to your medications and why, how to take them, and side effects you might experience
- Ask if you have any concerns about paying for your medications and help to find options for you if you aren't able to afford the cost of medication

Once you are home again, another health care professional—like your family doctor or nurse practitioner, a home care nurse, or a pharmacist—should talk with you about your medications to make sure they fully understand your medication needs.

### **For Clinicians**

*Hospital-based providers:* Work in partnership with patients and caregivers to complete medication reviews on admission and before discharge that include information regarding medication reconciliation, adherence, and optimization. Engage in a discussion with patients and caregivers about their ability and willingness to use their medications at home as recommended by their health care team, about supports that are available to assist with this, and about how to access medication in the community. You may need to consider such factors as:

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- The cost of medications and options for those unable to afford such costs
- Packaging instructions for those who may need assistance taking their medication (e.g., suggestion to use blister packs)
- Providing a short-term supply of medication until a prescription can be filled
- Reviewing the patient’s medication schedule, particularly when caregiver support is needed for medications that need to be delivered throughout the day and night
- Ensuring caregiver support is available when needed for people who need assistance with their medications
- Providing training on how to manage complex medication regimens

*Primary care providers and home and community care providers:* Once home, the patient’s most responsible provider (e.g., primary care provider, community pharmacist, home care nurse, rapid-response home nurse) should also complete a medication review that includes information regarding medication reconciliation, adherence, and optimization with the patient and their caregivers.

Review with the patient and caregivers how to use their medications effectively at home and how to access medication in the community. You may need to consider such factors as:

- The cost of medications and options for those unable to afford such costs
- Packaging instructions for those who may need assistance taking their medication (e.g., suggestion to use blister packs)
- Reviewing the patient’s medication schedule, particularly when caregiver support is needed for medications that need to be delivered around the clock
- Ensuring caregiver support is available when needed for people who need assistance with their medications
- Providing training on how to manage complex medication regimens

### **For Health Services**

Ensure hospitals have systems, processes, and resources in place for the hospital team to complete a medication review on admission and before discharge that includes information regarding medication reconciliation, adherence, and optimization.

Ensure systems, processes, and resources are in place for the most responsible community-based provider in the community to complete a medication review that includes information regarding medication reconciliation, adherence, and optimization.

## **Quality Indicators**

### *Process Indicators*

#### **Percentage of people discharged from hospital to home whose medications were reconciled at discharge**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator whose medications were reconciled at discharge
- Data source: local data collection
- Note: This indicator is included in the 2019/20 Hospital Quality Improvement Plans

**Percentage of people discharged from hospital to home whose discharge medication lists and clinical indications were provided to their community-based pharmacies upon discharge, including a full list of medications and follow-up appointments**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator whose discharge medication lists and clinical indications were provided to their community-based pharmacies upon discharge, including a full list of medications and follow-up appointments
- Data source: local data collection

*Outcome Indicators*

**Percentage of people discharged from hospital to home who have a drug-related emergency department visit or hospital readmission within 30 days after discharge**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who have a drug-related:
  - Emergency department visit within 30 days after discharge *or*
  - Hospital readmission within 30 days after discharge
- Data sources: Canadian Institute for Health Information, National Ambulatory Care Reporting System and Discharge Abstract Database

**Percentage of people discharged from hospital to home (or their caregivers) who report having a clear understanding of their prescribed medications**

- Denominator: total number of people discharged from hospital to home (or their caregivers)
- Numerator: number of people in the denominator who report having a clear understanding of their prescribed medications
- Data source: local data collection via patient survey
- Note: A similar survey question can be found in the Canadian Patient Experiences Survey<sup>41</sup>: “After you left the hospital, did you feel that you had the support and services you needed to help you manage your health condition at home?” (Response options: “Not at all, Partly, Quite a bit, Completely, Not applicable”)
- Exclusions: Those not taking any prescribed medications

## 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.

### Background

Ensuring people see a health care professional for follow-up medical care after discharge can help effectively manage their health conditions and identify worsening symptoms, side effects from medication changes, and self-management challenges.<sup>5</sup> Proper coordination among care providers following discharge—including follow-up medical care that is booked before discharge and the transfer of medical information among providers—is vital to ensure that people receive proper follow-up care and monitoring following their transition from hospital to home.<sup>10</sup>

People at high risk of readmission may need to have follow-up medical care sooner than those with a lower risk of readmission.<sup>8</sup> The health care team may choose to provide a follow-up phone call and/or home visit within 24 to 72 hours for selected patients to assess their ability and that of their caregivers to effectively manage care and ensure medications are being taken correctly.<sup>5,37,55</sup>

Patients sometimes experience difficulties scheduling medical appointments after they are discharged from hospital.<sup>10</sup> Ensuring that both primary care and specialist appointments are scheduled before patients leave hospital and ensuring that patients and caregivers have contact information for these visits can alleviate stress and ensure patients receive the follow-up care they need. If follow-up care needs to be arranged by the patient or a caregiver themselves, it is important to make sure this is explained to them and that they are given the appropriate contact information.

Some patients also face challenges with transportation to follow-up appointments (e.g., owing to their health condition, a lack of transportation, transportation costs, or geographical barriers). Further, people living in rural and remote communities have varied access to follow-up from primary care and specialists (Discharge Abstract Database, Ontario Health Insurance Plan Claims Database, Registered Persons Database 2016; data provided by ICES September 2018). Medical follow-up rates are lower among people discharged from small or remote hospitals, those who live in lower-income communities, and those who have reduced access to physicians in general.<sup>56</sup> For such individuals, a phone call, virtual follow-up, or home visit from a nurse or physician is the most appropriate mode for primary care follow-up.

**Sources:** Concept Mapping Patient Experience Research<sup>10</sup> | National Institute for Health and Care Excellence, 2015<sup>37</sup>

### Definitions Used Within This Quality Statement

#### Coordinated

Follow-up medical care should be scheduled before discharge, and patients and caregivers should be given contact information for these follow-ups. The person booking the follow-up care should consider the patient's and caregiver's schedules, as well as how to accommodate any needs regarding transportation, cost, distance, or physical mobility concerns. If the follow-up care cannot be booked before discharge, or if it is the patient's or a caregiver's responsibility to

book the follow-up care themselves, clear instructions and contact information should be given to the patient and caregiver before discharge.

### **Follow-up medical care**

Follow-up medical care is care provided in the community by the patient's primary care provider and/or specialists after the patient is discharged. Consideration should be given to the mode (e.g., face to face, telephone, virtual) and time frame for follow-up care that best suit patient and caregiver needs and preferences. The care providers responsible for making any follow-up calls should be identified before people leave the hospital.

## **What This Quality Statement Means**

### **For Patients**

Before you leave the hospital, your care team should:

- Arrange any follow-up care you need from your primary care provider or a specialist
- Give you clear instructions and contact information for this follow-up care

Sometimes, you or a caregiver may need to book a follow-up appointment. In this case, before you leave the hospital, someone at the hospital should:

- Give you clear instructions about the appointment and who you need to call to book your appointment

### **For Clinicians**

Coordinate and book follow-up medical care with the patient's primary care provider and/or specialists, as needed, before discharge. Ensure that recommendations for follow-up care are included in the patient's transition plan or discharge summary (see quality statement 5). Patients without a primary care provider can be referred to a local system, such as a family health team, where available. Patients can also contact Health Care Connect to search for a primary care provider.<sup>8,57</sup>

People at high risk of readmission may need to have follow-up medical care sooner than those at less risk of readmission.<sup>8</sup> For those at high risk of readmission, a follow-up phone call or home visit from a community-based nurse, nurse practitioner, physician assistant, or family physician should occur within 24 to 72 hours after discharge to assess the ability of people and caregivers to effectively manage care and ensure medications are being taken correctly.<sup>5,37,55</sup>

### **For Health Services**

Ensure hospitals have systems, processes, and resources in place to ensure that follow-up medical care can be coordinated and booked before discharge.

## Quality Indicators

### Process Indicators

#### **Percentage of people discharged from hospital to home who had follow-up medical care appointments coordinated and booked with their primary care provider (or most responsible provider) and/or medical specialist before discharge**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who had follow-up medical care appointments coordinated and booked with their primary care provider (or most responsible provider) and/or medical specialist before discharge
- Data source: local data collection
- Note: A validated survey question that can be used to inform local data collection is available in the Commonwealth Fund International Health Policy Survey<sup>50</sup>: “When you left the hospital, did the hospital make arrangements or make sure you had follow-up care with a doctor or other health care professional?” (Response options: “Yes, No, Not applicable/did not need follow up care, Not sure, Decline to answer”)

#### **Percentage of people discharged from hospital to home who have follow-up medical care appointments included in their transition plan or discharge summary**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who have follow-up medical care appointments included in their transition plan or discharge summary
- Data source: local data collection

## 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 services they and their caregivers need. These services are arranged before people leave hospital and are in place when they return home.

### Background

Appropriate referral for home care and community services, when needed, is essential to the transition process and has been shown to reduce the rate of hospital readmissions.<sup>37,58</sup>

Research regarding what affects Ontarians' experiences of the care they receive during transitions from hospital to home most commonly reflects challenges with home care, including the timeliness, reliability, consistency, and sufficiency of publicly funded services.<sup>10</sup> Many rely on family, friends, private services, or charities to fill the gap. Timely and appropriate home care and community services help people transitioning from hospital to home feel more comfortable and confident in their ability to care for themselves when they return home.<sup>10</sup>

Arranging the logistics of home care, whether involving clinical health services, medical equipment, personal support workers, or nonclinical support services, can often be overwhelming for patients, families, and caregivers.<sup>10</sup> In assessing the need for home care and community services, health care professionals should consider all aspects of a person's health, including their functional, social, cognitive, and mental health needs.<sup>2</sup> Regardless of where people live in Ontario, assessments for home care and community services should be performed consistently, including the process used to determine the type and amount of care a person will need.<sup>2</sup> Many factors may affect the type and amount of care a person may need, including the following<sup>2</sup>:

- Social factors such as low income, unstable housing, living alone, and complex family dynamics
- Complex health issues such as mental health conditions, addiction, significant cognitive impairment, or the presence of multiple comorbidities
- Caregiver willingness and capacity to provide care

People transitioning from hospital to home and their caregivers should be assigned a home and community care coordinator who will work with the hospital team and the patient to understand the patient's goals and preferences, assess their home care and community support service needs, develop a care plan to meet their needs and achieve their goals, and arrange and coordinate access to timely and appropriate home care and community support services and other programs, as needed.<sup>2</sup> Communication and alignment across the integrated care team are needed to ensure appropriate and timely logistical support.

**Sources:** Concept Mapping Patient Experience Research<sup>10</sup> | National Institute for Health and Care Excellence, 2015<sup>37</sup>



## Definitions Used Within This Quality Statement

### Home care and community services<sup>59</sup>

Home care includes the following:

- Clinical health services (e.g., dietetics, medical care, mental health care, nursing, occupational therapy, palliative care, physiotherapy, social work, speech-language therapy)
- Homemaking support (e.g., help with cleaning, laundry, or meal preparation)
- Personal support services and other related services

Community services are nonclinical support services; for example, assistance with meal preparation or meal delivery, home help, mental health support, and transportation assistance.

### Assessment of home care and community service needs

This assessment considers the functional, medical, equipment, home accommodation and/or modification, cognitive, mental health, and social support needs of the person and their caregivers to determine the type and amount of home care and community services they will need after leaving hospital. (An example of such a tool is the InterRAI Contact Assessment.<sup>60</sup>)

The amount of support a person needs can be considered in terms of short- and long-term support. Short-term support is provided over a matter of days up to several weeks. Long-term support is provided for a length of time beyond several weeks. Examples of short-term support include post-acute medical or surgical needs. Examples of long-term support include, for example, care for people with functional limitations, chronic health issues, or medically complex care needs.

The assessment should also include a consideration of the patient's ability to pay for any out-of-pocket costs.

## What This Quality Statement Means

### For Patients

If you need health care, personal support care, or assistance from other community services once you are back home, a care coordinator should work with you and your hospital care providers to arrange the services before you leave the hospital. (These services include things like home visits from a nurse or doctor to help with your medical care, help with preparing meals or cleaning, and help with transportation to medical appointments.)

### For Clinicians

For patients needing home care or community services following discharge, a home and community care coordinator should be assigned to assess the patient's (and caregiver's) needs and arrange for services. The care coordinator should work with the hospital- and community-based teams, and with the patient and caregiver, to assess the patient's needs. Include details of the arranged services in the transition plan or discharge summary. The patient's need for home care or community services should be reassessed regularly.

### For Health Services

Ensure that systems, processes, and resources are in place for people transitioning from hospital to home to have timely and equitable access to the home care and community services



they need, when they need them, by providing adequately resourced systems and services. Work collaboratively with stakeholders, communities, and people with lived experience, using local data and evidence, to plan and develop home care and community services that meet the needs of all people transitioning from hospital to home, particularly those who are socially disadvantaged or face barriers to accessing care. Ensure that health care professionals are aware of the home care and community support services that are available to their patients and how to arrange for these services.

## Quality Indicators

### Process Indicator

#### **Median wait time from hospital discharge to first home care service date for people approved for home care services**

- Population: people discharged from hospital to home with new home care services arranged
- Potential stratification: home care service type
- Data source: Home Care Database (Ministry of Health and Long-Term Care)

### Outcome Indicators

#### **Percentage of people discharged from hospital to home referred for home care and community services who report receiving enough hours of home care services**

- Denominator: total number of people discharged from hospital to home referred for home care and community services
- Numerator: number of people in the denominator who report receiving enough hours of home care services
- Data source: local data collection via patient survey
- Note: A validated survey question that can be used to inform local data collection is available in the Home and Community Care Client Experience Survey (still in development)<sup>48</sup>: “Do you receive enough hours of home care?” (Response options: “I receive more than enough, I receive enough, I need a little more, I need a lot more, Do not know/do not remember”)
- Exclusion: people who reply “Do not know/do not remember”

#### **Percentage of people discharged from hospital to home who received home care and community services who report that their home care started when they needed it to**

- Denominator: total number of people discharged from hospital to home who received home care and community services
- Numerator: number of people in the denominator who report that their home care started when they needed it to
- Data source: local data collection via patient survey
- Note: A validated survey question that can be used to inform local data collection is available in the Home and Community Care Client Experience Survey (still in development)<sup>48</sup>: “Would you agree that your home care started when you needed it?” (Response options: “Yes, No, Do not know/do not remember”)
- Exclusion: people who reply “Do not know/do not remember”

## 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 assessed by the health care team, and alternatives for unaffordable costs are considered 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.

### Background

Patients and caregivers in Ontario who have experienced transitions from hospital to home have identified challenges related to paying for out-of-pocket costs for medications, medical equipment, transportation, and home care services.<sup>10</sup> Limited coverage and lengthy wait times for publicly funded home care and community-based services (e.g., occupational therapy, physiotherapy, other rehabilitation services) have also been recognized as priority areas for improvement by patients and caregivers<sup>10</sup>; these issues have also been identified as related to the need for equitable access to care.<sup>61-63</sup> A recent report from the Expert Group on Home and Community Care states that “family and caregivers need access to and funding of a core consistent ‘basket of services’ that recognizes nonclinical supports such as homemaking, meal preparation, supportive housing, transportation and respite.”<sup>59</sup> These issues present many challenges for patients, families, and caregivers, and how these issues are addressed significantly impacts the success of transitions from hospital to home.<sup>10</sup>

People transitioning from hospital to home and their caregivers need accurate information about the availability of funded and unfunded services and how to access them. They also need to be provided with accurate information about what services they will need to pay for.<sup>59</sup> For those unable to pay for unfunded or partially funded community-based services, support should be provided by health care professionals and/or a home and community care coordinator to ensure their care needs are met. Without this support, many will go without care.

**Source:** Concept Mapping Patient Experience Research<sup>10</sup>

### Definitions Used Within This Quality Statement

#### Health care team

This includes the hospital-based and community-based interprofessional health care team, and if required home and community care coordinators and/or social workers. They provide information and planning related to both funded and non-funded services (i.e., linking to health and community supports services that are funded and not funded). They let patients and their caregivers know any out-of-pocket costs (when known) and assist with reviewing other funding sources (e.g., March of Dimes, Ontario Disabilities Support Program, Ontario Drug Benefit program Ontario Works). In some hospitals, the social worker and home and community care coordinator are often integrated and do this solely. In other hospitals they are separate professions doing different pieces of this role together.

#### Out-of-pocket health care costs

This could include, but is not limited to, any unfunded community-based physiotherapy, occupational therapy and/or other rehabilitation services; medications; medically-necessary equipment and medical supplies; support services (such as housecleaning, laundry, or meals); and personal support workers (e.g., personal care).

## What This Quality Statement Means

### For Patients

Before you leave the hospital, a health care professional should:

- Let you know about any health or community support services you will need once you are home again
- Explain the services that require you to pay all or part of the cost and options you can explore if you can't afford to pay for some services

### For Clinicians

Work together with your fellow health care providers (from both the community and hospital), and, if required, home and community care coordinators and/or social workers, to provide people transitioning from hospital to home and their caregivers with information regarding which health and community support services are funded and which are not. Explain to patients and their caregivers which services they will need to pay for. For those who will need assistance paying, help them find alternative sources of funding (e.g., through the March of Dimes or through a government program such as the Ontario Disabilities Support Program, Ontario Works, or the Ontario Drug Benefit program).

### For Health Services

Ensure that systems, processes, and resources are in place for the health care team, and if required home and community care coordinators and/or social workers (from community and hospital), to work together to provide information and planning for health and community supports services that are funded and not funded.

## Quality Indicators

### *Process Indicator*

#### **Percentage of people discharged from hospital to home whose ability to pay for out-of-pocket health care costs is assessed by their health care team**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator whose ability to pay for out-of-pocket health care costs is assessed by their health care team
- Data source: local data collection

### *Outcome Indicator*

#### **Percentage of people discharged from hospital to home who report not receiving the help they needed because of the cost**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report not receiving the help they needed because of the cost
- Data source: local data collection via patient survey
- Note: An example of a validated survey question that can be used to inform your local data collection is available in the Commonwealth Fund International Health Policy Survey<sup>50</sup>: “In the past year, was there a time you did NOT receive the help you needed because of the cost?” (Response options: Yes, No, Not sure, Decline to answer)

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We focus on making health care more effective, efficient and affordable through a legislative mandate of:

- Reporting to the public, organizations, government and health care providers on how the health system is performing,
- Finding the best evidence of what works, and
- Translating this evidence into clinical standards; recommendations to health care professionals and funders; and tools that health care providers can easily put into practice to make improvements.

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