transitions in care

what we heard

Early in 2018, Health Quality Ontario asked Ontarians a simple question: **what affected your transition from hospital to home?**

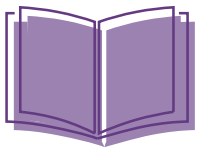
Good and bad. Big and small. We wanted to hear from patients, families and caregivers.

In surveys, interviews and in groups, more than 600 people from across the province shared their stories and 2,600+ notable details that make a good transition home.

Here are the big themes that emerged in conversation:

respect + compassion

effective communication



patient education

follow-up care

medication support

timely + appropriate home care

Theme 1: **respect + compassion**

The way patients, family members, and caregivers are treated, both before and after leaving the hospital, can affect the success or failure of their transition. We heard that when patients, particularly those in vulnerable groups, **felt respected, included and listened to**, their journey home went more smoothly.

> *The resident doctor **actually took the time to listen** to my concerns about discharge without notice. She also agreed with my suggestion that my mom have a geriatric assessment and made a referral. I work in healthcare and I know what's available— many don't and don't know who to ask. People rely so heavily on the doctor discharging for info. **I've never been listened to before— just told.** This change was so helpful to me as I cared for my mom.*

Theme 2: **effective communication**

The discharge process itself can be complicated, with many health care practitioners, allied health, and hospital staff involved. Patients and families told us that **communication** is key to good **discharge planning**, especially having the time and opportunity to ask questions and actively participate in the process. Communication about discharge **timing and logistics**—when and how patients are transported home—are also factors, and can be especially important for vulnerable or isolated populations.

> *I did not have anyone to pick me up or any money to get home. So I had to walk.* ***It was a five-mile walk.***

Theme 3: **patient education**

Receiving clear instructions on what to do upon arriving at home, whether the guidance is **verbal or written**, can ease anxiety and provide comfort to patients and their families. Knowing who to call for help in the event that questions or unexpected symptoms come up can also be enormously helpful.

> *I think there would be **huge benefit in telephone follow-ups** immediately post-discharge with patients and caregivers. My mother's risk of readmit was low, but it would have reduced anxiety if [I'd] **had the chance to talk with someone** the day after discharge.*

Theme 4: **timely + appropriate home care**

By far the most common feedback we heard, from all corners of the province, was how **timely and appropriate home care** could help patients feel more comfortable and confident back at home. The logistics of home care, whether it involves Allied Health, equipment, nursing or Personal Support Workers, can often feel overwhelming for patients, families, friends and caregivers.

> *The doctor in charge connected me with the CCAC person* ***who made arrangements for me to get immediate help at home****, three hours away. The nurse was there and the IV equipment was delivered so she could* ***keep me on schedule****.*

Theme 5: **medication support**

Transitions from hospital to home often involve managing changes in **medications**. Patients and families told us about the importance of being able to **review medications with a health care provider**. Also crucial to a successful transition: understanding comfort levels around managing complex medications, being able to handle the cost of medications, knowing how to deal with pain and feeling confident about taking the right medications at the right dosage.

> *When I got home with my husband I had questions about his medications but* ***didn't know who to ask.***

Theme 6: **follow-up care**

Patients let us know that **medical care does not stop once they transition home.** Proper coordination—including timely follow-up appointments that are easy to get to, and the transfer of medical data between practitioners—is vital to prevent readmissions.

> *Le **transfert d'information** l'hopitale de Toronto et le centre d'accueil au Québec s'est bien passé.*

What's Next?

This is just the beginning. We've heard from Ontarians about the factors that have the greatest impact on their transition from hospital to home.

Now we want to understand which factors are most important? What should be a priority for improvement in Ontario?

In the summer and fall of 2018, Health Quality Ontario will reach out again, asking patients, families and caregivers to rank their priorities from all the ideas that were shared.

These priorities will be used to develop a set of provincial standards for high-quality care during transitions—to support health professionals to know what good care looks like during transitions, and to improve the care patients receive upon leaving the hospital.

We look forward to speaking with you soon.

Engagement Approach

Health Quality Ontario's patient engagement team, along with community group members, and public representatives, came together to develop an outreach and communications strategy. To spread information about this project, the engagement team used print pieces (posters and flyers), as well as direct email, website updates and social media.

Participants were able to share their experiences and input online, and in-person during group discussions held around the province.

665 responses completed online + 8 discussion groups done in-person, across Ontario*

*including Toronto, Ottawa, Waterloo, North Bay, and Portland.

= **2,704 ideas**

Who were our participants?**

Online Respondents	
Patients	313
Caregivers	402

Discharged To…	
Apartment / House / Residence	635
Rehab or Chronic Care	54
Long Term Care or Nursing Home	30
Other	24

** Totals differ from the overall number of participants as not everyone chose to share demographic information, and some responded as both patients and caregivers.

Online Number of Respondents Who…	
Live in a Community North of Sudbury	61
Live in a rural community	83
Were admitted to hospital more than once in the past year	202
Live alone	148
Sometimes have difficulty making ends meet	79
Do not have a college or university degree	172
Have a physical, sensory, or developmental disability	126
Were admitted to hospital due to mental health issues	23
Prefer to speak a language other than English with their health care team	46
Caring for patients who are children	29

About this Project

The journey home after hospital admission is challenging.
It is a time of stress for the patient, their family and the health care system. Poor transitions increase the risk of complications and can put a strain on the system. We know our health system can do better.

What factors matter most to patients? What affects their journey home?

To answer these questions, Health Quality Ontario, in collaboration with Tara Kiran, a researcher funded by the Canadian Institutes of Health Research, is reaching out across the province to hear from patients, caregivers, and families about their experiences with the transition from hospital to home.

For more information about this project, visit:
hqontario.ca/transitions

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