Transitions from Hospital to Home *Quality Standard*

Quality Standards

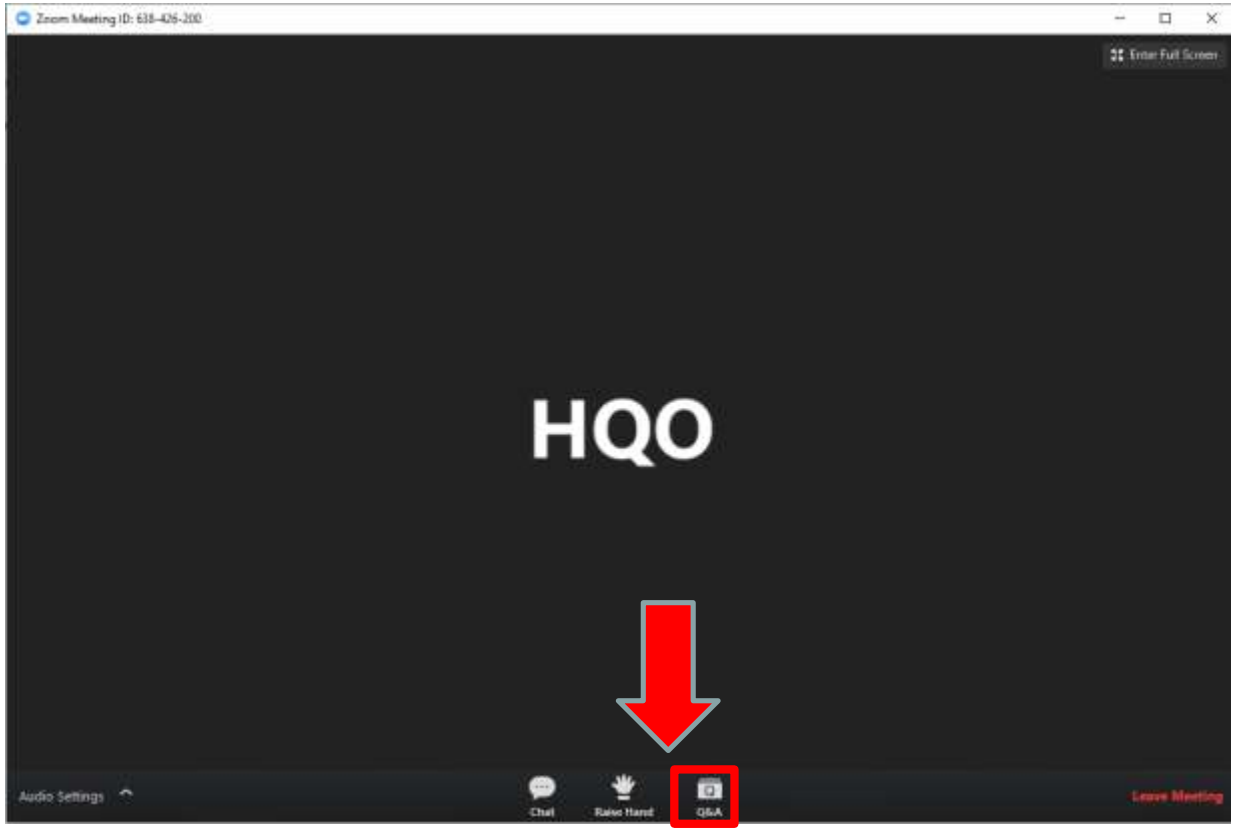
Health Quality Ontario

Let's make our health system healthier

Today's Agenda

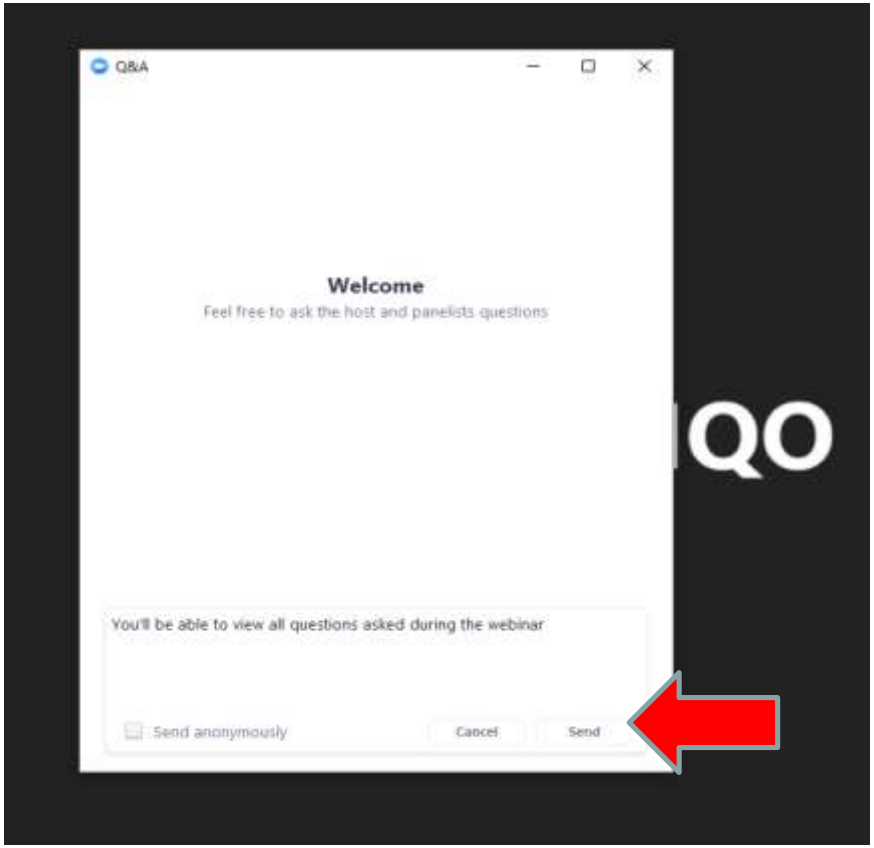
- What is a quality standard?
- Why one on the transition from hospital to home?
- What did we learn from patients, in prep?
- What does the draft standard say to do?
- How to give us feedback
- Supports you can use to implement the standard
- Questions and comments

How to Participate in the Q&A



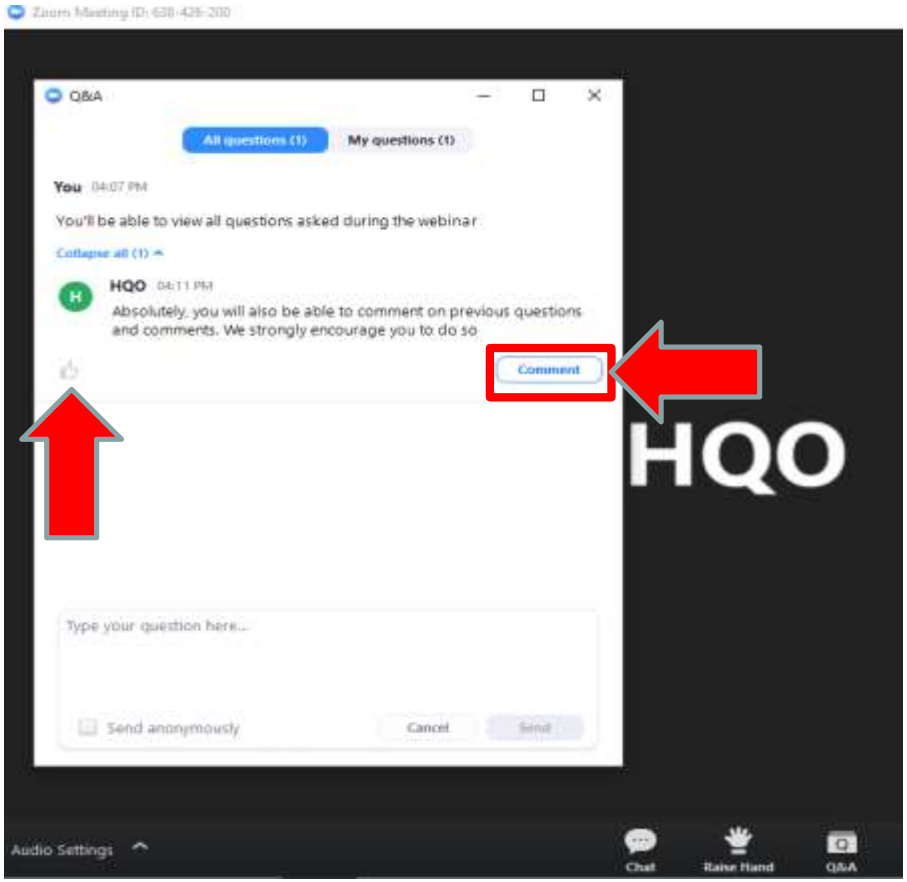
- Please use the Q&A box to ask questions related to today's presentation
- Our Transitions Quality Standards Team will be answering questions throughout the presentation
- We will do our best to answer all questions however, due to the volume of attendees, we may not be able to answer everyone.

How to Participate in the Q&A



- Questions can be asked by typing into the Q&A box below and clicking send

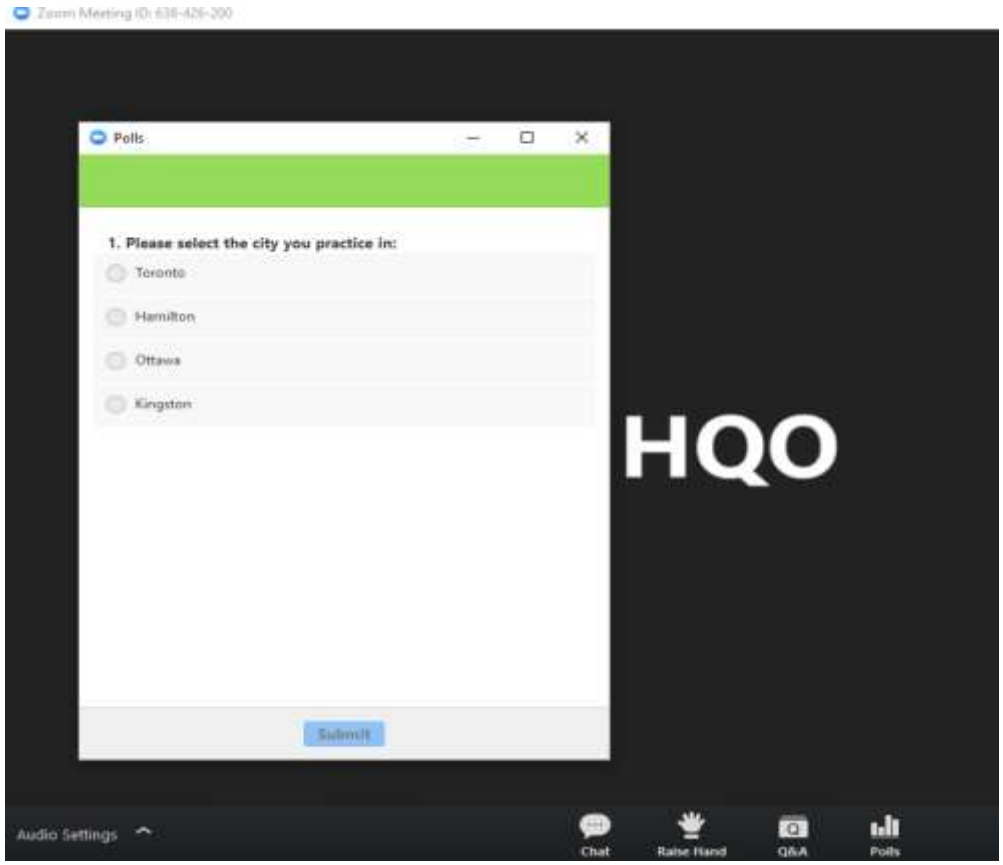
How to Participate in the Q&A



- Once a question has been asked it will appear to all of the attendees

- We have enabled the **comment option**, which allows you to comment on a question posted by another attendee.
  - Much like a web forum. You can also “Like” a comment to show you support.

How to Participate in Today's Polls



- Once we launch a poll, it will appear on your on your screen.
- Select your desired answer an click submit.
- Once finished, the results of the poll will appear on your screen.

Poll: Joining Us Today?

Tell us your primary role in the health care system

A. Patient or unpaid caregiver

B. Health care provider

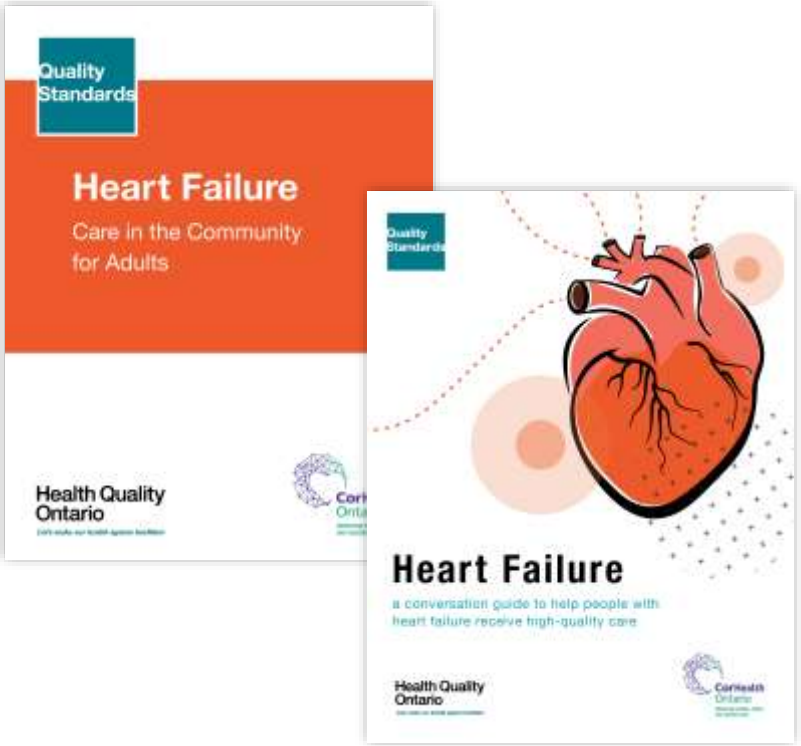
C. Both A and B

D. None of the above

Poll: What do patients feel most affects their transition from hospital to home?

A. Being involved in planning the transition
B. Receiving a clear written transition/discharge plan
C. Education to take medications correctly
D. Having timely follow-up appointments
E. Receiving timely and appropriate home care
F. Out-of-pocket costs

Quality Standards



Who Benefits

Patient and Caregivers

Direct-Care Organizations

Health Care Professionals

Patient/Condition Groups

Government

Why Do We Need a Quality Standard for Patient Transitions from Hospital to Home?

When Care Transitions Are Not Managed Well

Patients may suffer from errors and delays in care. This can result in:

- Negative patient experience
- Avoidable hospital re-admissions
- Avoidable emergency department visits
- Increased health care costs

Source: Coleman EA, Boult C. Improving the quality of transitional care for persons with complex care needs. J Am Geriatr Soc. 2003; 51(4):556–7.

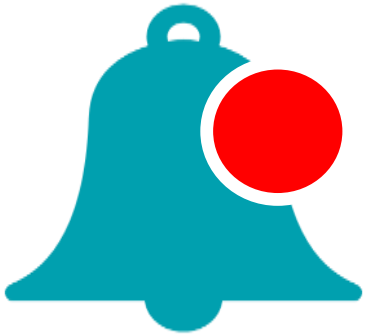
Some Alarming Stats

Only **59%** of people discharged from hospital were aware of which danger signs to look out for at home

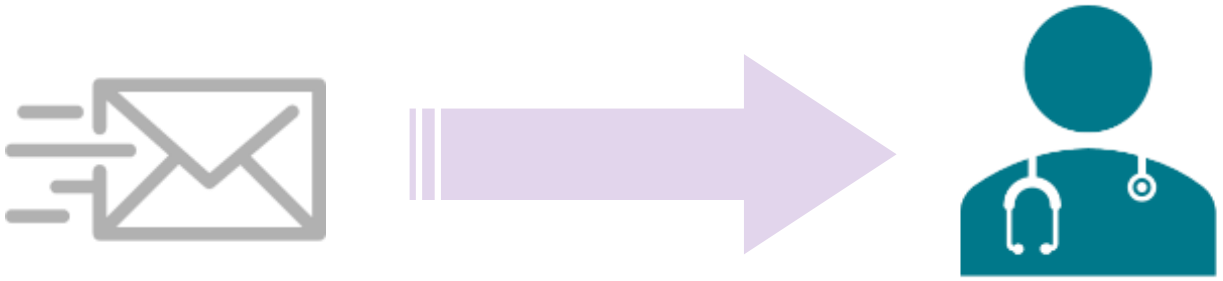
Only **52%** knew when to resume their usual activities when discharged from hospital

83% of patients reported knowing how to take their medications when leaving the ED. However, 30% did not know which side effects to look out for and 38% did not know who to call if they needed help

Source: Health Quality Ontario. Quality Monitor: 2012 report on Ontario's health system [Internet]. Toronto (ON): Queen's Printer for Ontario; 2012 [cited 2017 Jun 9]. Available from: http://www.hqontario.ca/portals/0/Documents/pr/qmonitor-full-report-2012-en.pdf



About 30% of Ontario family doctors say they only sometimes, rarely or never receive notification when their patient is discharged from hospital



Family doctors report that it often takes **many days** to receive this information - just over half (54%) of family doctors report it taking, on average, up to 4 days to receive this information

Source: Health Quality Ontario. Connecting the dots for patients: Family doctors' views on coordinating patient care in Ontario's health system. Toronto (ON): Queen's Printer for Ontario; 2017

The Quality Standard's Scope

Quality Priorities for the 2019/20 Quality Improvement Plans

Health Quality Ontario
Let's make our health system healthier

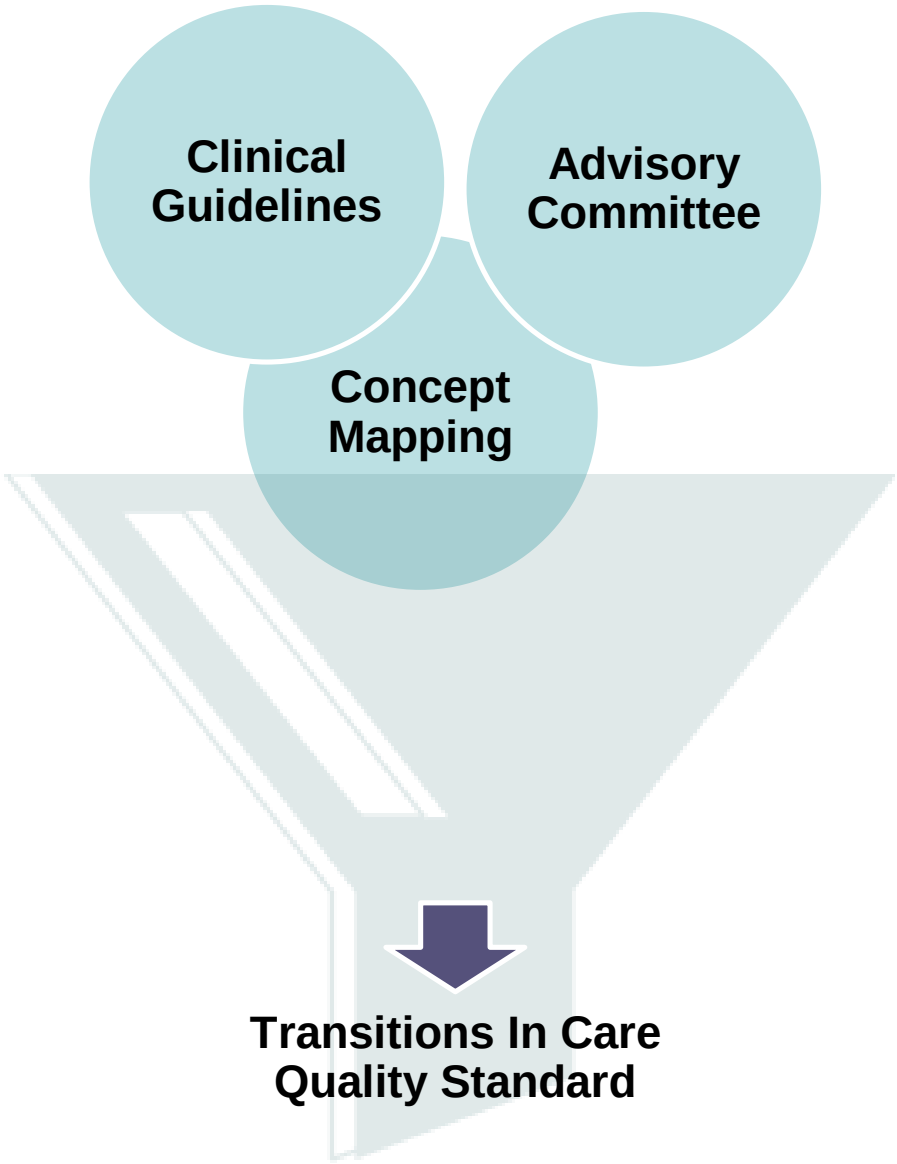
	Hospital	Primary Care	Home and Community Care	Long-Term Care
	THEME I: TIMELY AND EFFICIENT TRANSITIONS			
Efficient	• Alternate level of care (ALC) rate • NEW Number of inpatients receiving care in unconventional spaces or ER stretchers	• 7-day post-hospital discharge follow-up	• Unplanned emergency department visits within 30 days of hospital discharge	• Potentially avoidable emergency departments visits
Timely	• NEW Time to inpatient bed * • Discharge summaries sent from hospital to primary care provider within 48 hours of discharge	• Timely access to a primary care provider	• NEW Wait time to long-term care home placement	
	THEME II: SERVICE EXCELLENCE			
Patient-centred	• Patient experience: Did you receive enough information when you left the hospital? • Complaints acknowledged in a timely manner	• Patient involvement in decisions about care	• Percentage of patients satisfied with services • Complaints acknowledged in a timely manner	• Resident experience • Complaints acknowledged in a timely manner
	THEME III: SAFE AND EFFECTIVE CARE			
Safe	• Number of workplace violence incidents (overall) *	• NEW Percentage of non-palliative care patients newly dispensed an opioid		
Effective	• NEW Early identification: Documented assessment of palliative care needs for an early, at-risk cohort • Readmission within 30 days for mental health and addiction • Medication reconciliation at discharge	• NEW Early identification: Documented assessment of palliative care needs for an early, at-risk cohort	• NEW Early identification: Documented assessment of palliative care needs for an early, at-risk cohort	• NEW Early identification: Documented assessment of palliative care needs for an early, at-risk cohort
	Equitable			

** Mandatory indicator (hospital sector only)*

Updated: January 29, 2019

How Was This Quality Standard Developed?

Evidence Inputs



Patient Partnering

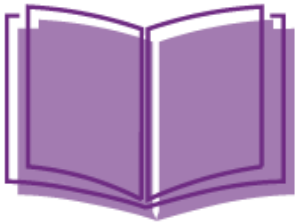
More than **1,100** patients and caregivers consulted through **1,122** surveys and **8** discussion groups

Source: Transitions in Care: What We Heard, Health Quality Ontario

Patient Priorities

respect + compassion

effective communication



patient education

follow-up care

medication support

timely + appropriate home care

Top Rated Statements

Not enough publicly-funded home care services to meet the need

"Limited hours offered by CCAC to support a failing 90 year old woman in her own apartment"

Home care support is not in place when arriving home

"My father received home care after a week, not 24 hours as indicated by hospital discharge staff"

Having to advocate to get enough home care

"Had little to no help from care coordinators. Had to 'fight' to get help"

What Key Activities Will Improve Transitions?

Statement Themes


1. Information-sharing on admission


2. Comprehensive assessment


3. Patient, family, and caregiver involvement in transition planning


4. Patient, family, and caregiver education, training, and support


5. Transition plans


6. Coordinated transitions

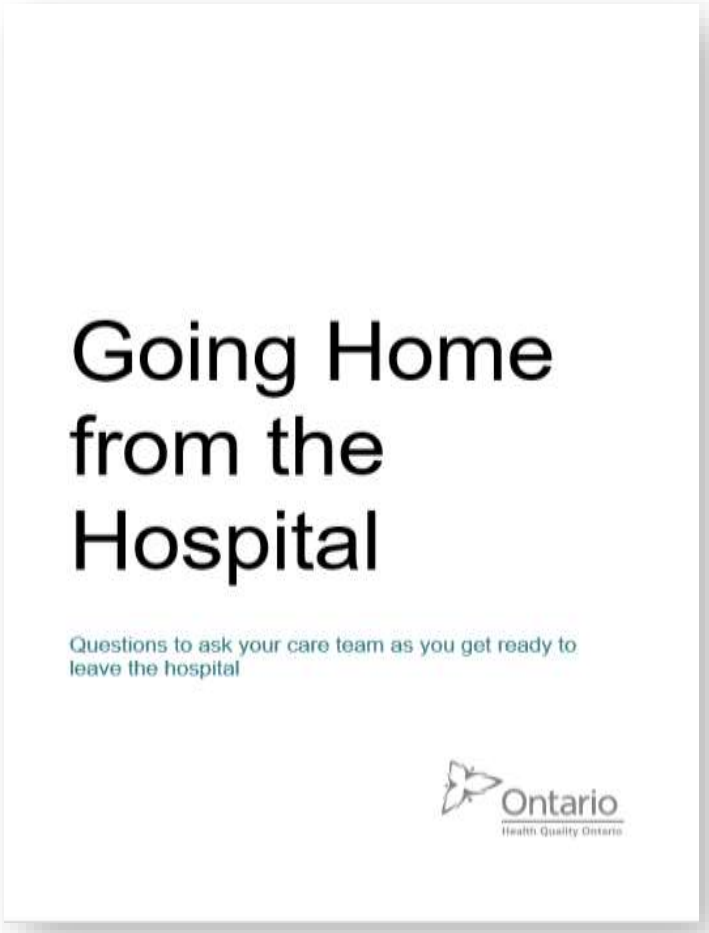

7. Medication review and support


8. Coordinated follow-up medical care


9. Appropriate and timely logistical support for home and community care


10. Uncovered costs and limits of funded services

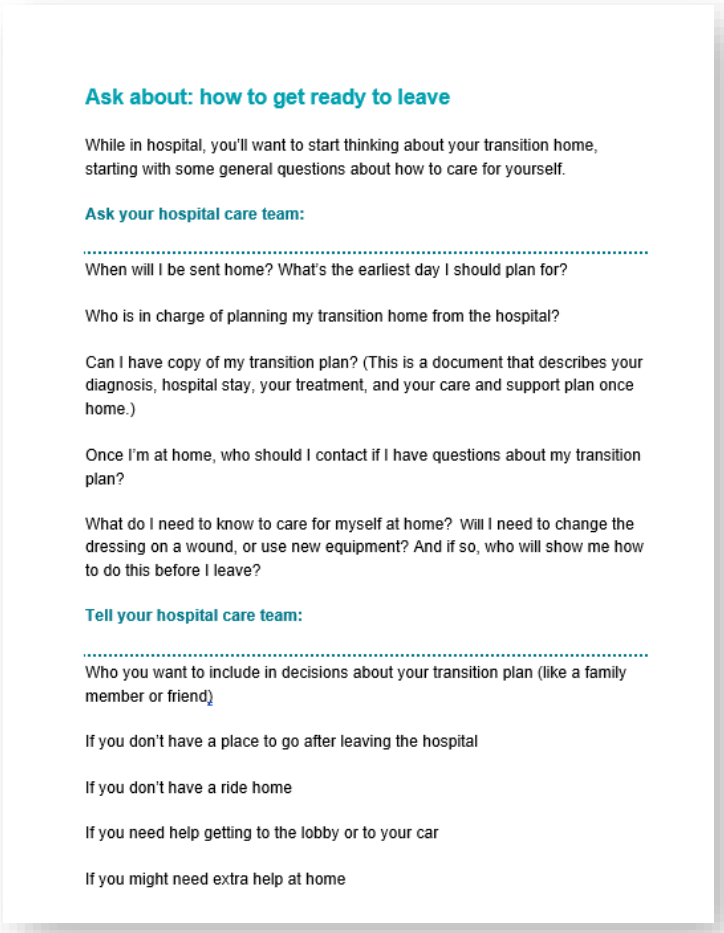
Patient Guide



Going Home from the Hospital

Questions to ask your care team as you get ready to leave the hospital

Ontario
Health Quality Ontario



Ask about: how to get ready to leave

While in hospital, you'll want to start thinking about your transition home, starting with some general questions about how to care for yourself.

Ask your hospital care team:

When will I be sent home? What's the earliest day I should plan for?

Who is in charge of planning my transition home from the hospital?

Can I have copy of my transition plan? (This is a document that describes your diagnosis, hospital stay, your treatment, and your care and support plan once home.)

Once I'm at home, who should I contact if I have questions about my transition plan?

What do I need to know to care for myself at home? Will I need to change the dressing on a wound, or use new equipment? And if so, who will show me how to do this before I leave?

Tell your hospital care team:

Who you want to include in decisions about your transition plan (like a family member or friend)

If you don't have a place to go after leaving the hospital

If you don't have a ride home

If you need help getting to the lobby or to your car

If you might need extra help at home

How To Give Us Feedback

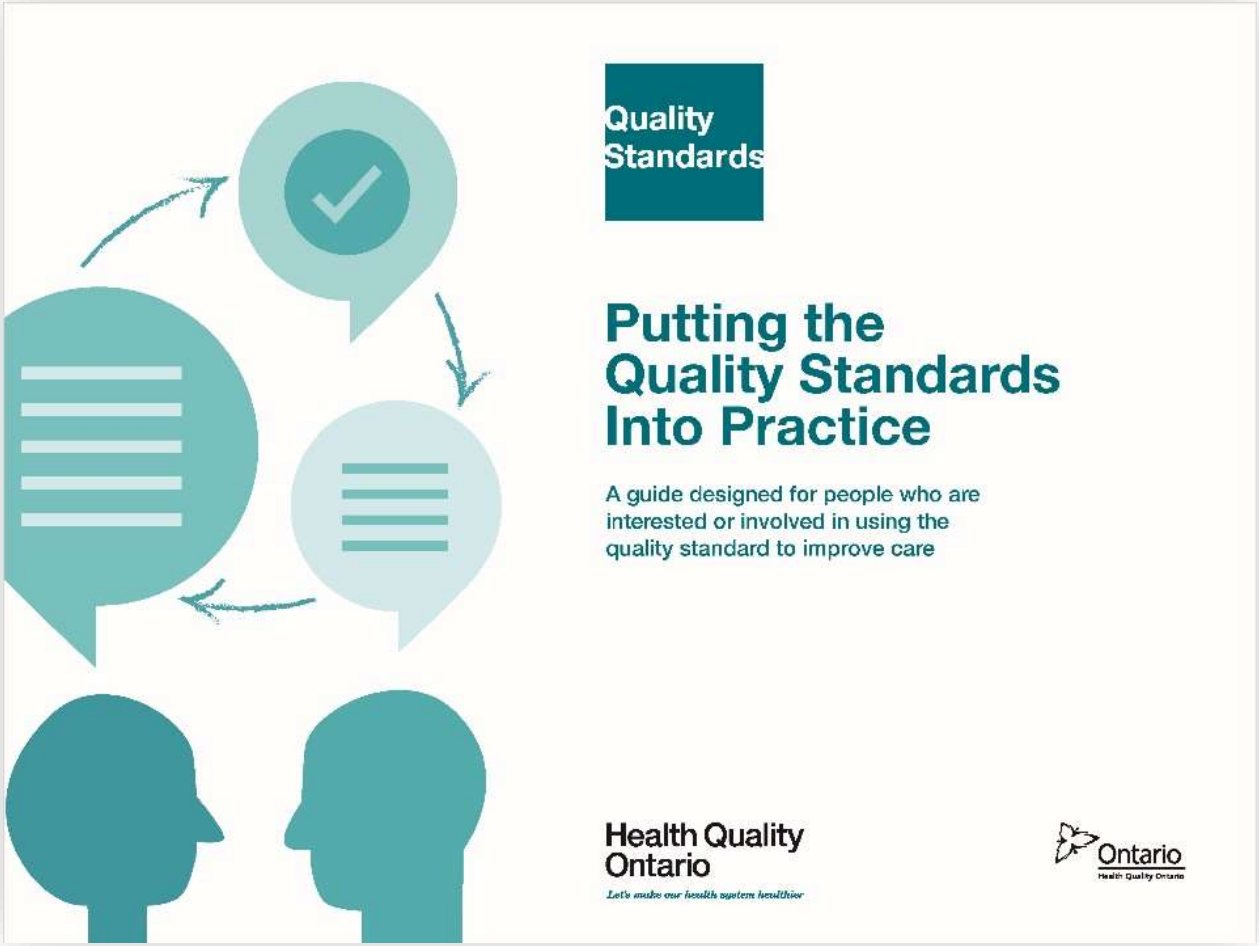
Share Your Feedback Online

- **Public comment:**
  Open until May 14, 2019
- **Visit:**
  www.hqontario.ca/Transitions
- **Share your feedback:**
  On the Quality Standard, the Patient Guide, or both**!**

Discussion and questions

Supports You Can Use to Implement the Standard

Getting Started Guide



Patient Oriented Discharge Summary (PODS)

Quorum

10
1625

Improving Access to Cognitive Behavioural Therapy at Scarborough and Rouge Hospital

By Shawnna Balasingham posted on 2017-11-16

This post is part of a series about how quality standards can be used to support quality improvement together with others who are working on adopting the quality standards. The introductory post can be found here. A.K is a 27-year-old female

Tags: ACCESS TO RIGHT LEVEL OF CARE | CE LHIN | HOSPITAL | MENTAL HEALTH | QUALITY STANDARDS ADOPTION

6
1246

Using the Major Depression Quality Standard to Restructure our Psychiatry Program

By Geneviève Arturi posted on 2017-09-26

This post is part of a series about how quality standards can be used to support quality improvement together with others who are working on adopting the quality standards. The introductory post can be found here. At Hawkesbury and District

Tags: CHAMPLAIN LHIN | HOSPITAL | MAJOR DEPRESSION | MENTAL HEALTH | QUALITY STANDARDS ADOPTION

4
1412

Creating a geriatric mental health pathway at Niagara Health

By Barb Pizzingrilli posted on 2017-09-05

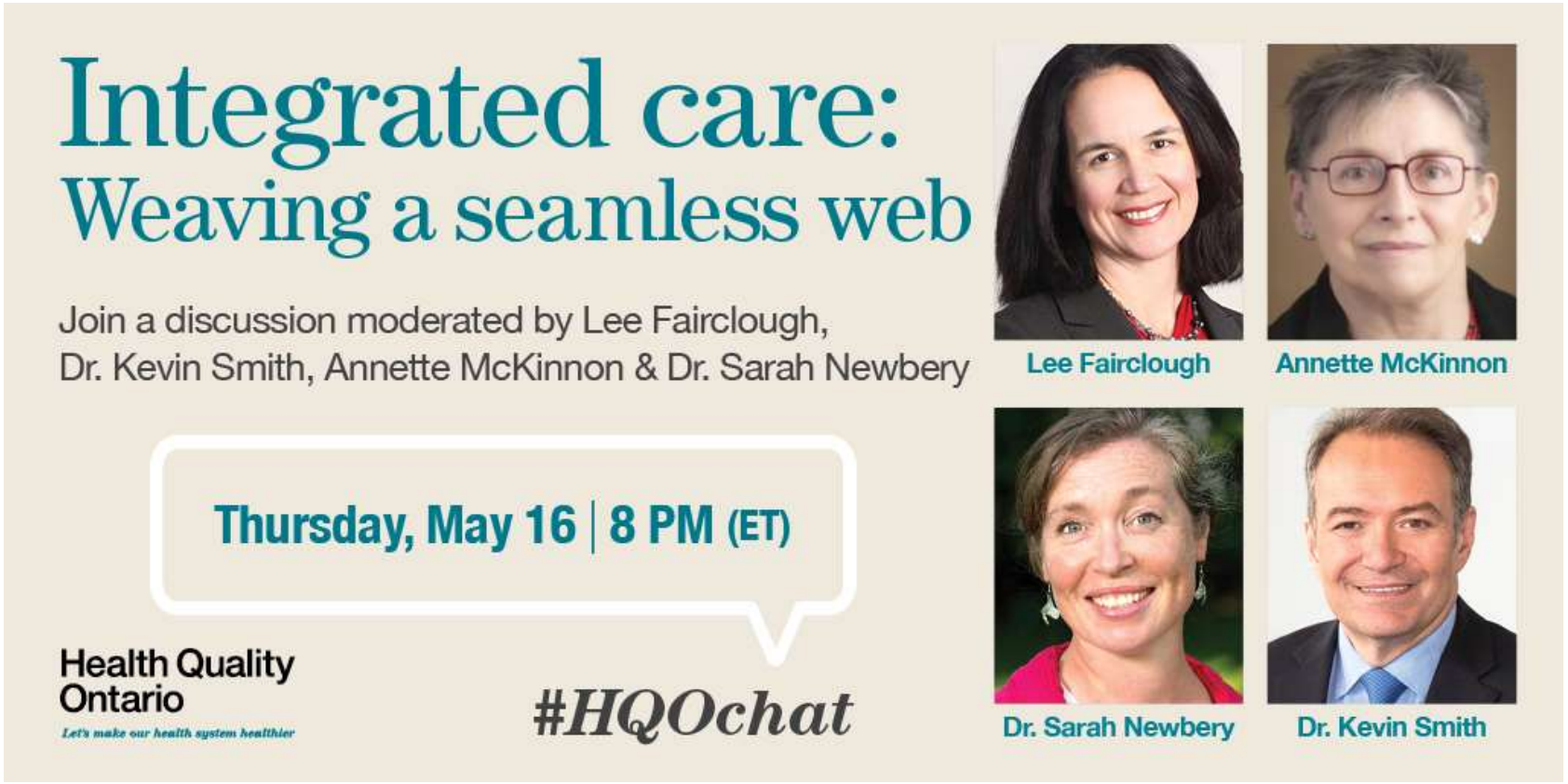
This post is part of a series about how quality standards can be used to support quality improvement together with others who are working on adopting the quality standards. The introductory post can be found here. From years of experience in

Tags: HNHB LHIN | HOSPITAL | MENTAL HEALTH | QUALITY STANDARDS ADOPTION

Join our Twitter Chat: #HQOchat

May 16th at 8pm (ET)

What does integrated care mean to you?



Thank you.

LET'S CONTINUE THE CONVERSATION:

hqontario.ca

@HQOntario

HealthQualityOntario

@HQOntario

Health Quality Ontario

Connect with us:
www.hqontario.ca

Health Quality Ontario

Let's make our health system healthier

Evidence Mapped to Quality Statement Topics

Topic Areas Prioritized by QSAC (Guidelines and Patient Experiences as Inputs)	**Quality Statement Topics**
• Assessment and care planning (before and upon admission to hospital) • Communication and information sharing with home and community care throughout transition (**upon admission** and at discharge from hospital)	**QS 1:** Information-Sharing on Admission **QS 2:** Comprehensive Assessment
• Communication about discharge and development of discharge plans • Communication and information sharing with home and community care throughout transition (upon admission and at **discharge from hospital**) • Uncovered costs and limits of funded services	**QS 6:** Coordinated Transitions **QS 5:** Transition Plans
• Family and caregiver involvement in discharge planning	**QS 3:** Patient, Family and Caregiver Involvement in Transition Planning
• Medication review and support • Uncovered costs and limits of funded services	**QS 7:** Medication Review and Support
• Patient, family and caregiver information and education	**QS 4:** Patient, Family and Caregiver Education, Training and Support
• Home Care and medical care in the community • Timely services and logistical support after discharge • Uncovered costs and limits of funded services	**QS 8:** Coordinated Follow-Up Medical Care **QS 9:** Appropriate and Timely Support for Home and Community Care
• Uncovered costs and limits of funded services	**QS 10:** Out-of-Pocket Costs and Limits of Funded Services
• Health care professional education and training	Reflected in RFAs