



**Adopting a Common Approach to Transitional Care Planning:
Helping Health Links Improve Transitions and Coordination of Care**



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Introduction

This document, *Adopting a Common Approach to Transitional Care Planning*, is a tool to promote standardization in transitional care practices, within and across Health Links, for complex patients. The importance of robust transitional care planning and the benefits of using common approaches to the transition process are described within this guide.

This guide recommends a total of nine practices for transitional care, which are divided into three main categories:

a) Pre-Transition Practices

1. Pre-transition planning is incorporated as a standard of care for complex patients admitted to a health care facility
2. Patients and caregivers are involved as partners in the transition planning process
3. Individualized comprehensive assessments and care plans are developed for complex patients on admission

b) Transition Planning Practices

4. Individualized transitional care plans are developed on admission for patients with complex needs
5. Protocols are established to ensure medication reconciliation at key transition points
6. Families/caregivers are provided with information and resources to support their transition

c) Assessing Post-Transition Risk and Activating Post-Transition Follow-up

7. Standardized risk assessment tools are used to assess and stratify complex patients
8. Appointments are booked with the patient's primary care provider
9. Complex patients receive a follow up phone call within 48 hours of discharge from hospital

Below, the underlying principles supporting the adoption of a common approach to transitional care planning across Health Links are noted. Each of the nine practices are also listed and accompanied by descriptions of ideas for implementation that build on recurrent themes and approaches described in the relevant literature and are currently being used in Ontario.

Securing the buy-in of Health Link and Local Health Integration Network (LHIN) leaders is crucial to success. Likewise, the importance of clarifying accountability within and among providers cannot be over-emphasized. It is recommended that each Health Link establish a mechanism, such as a working group, which will help to ensure that buy-in is achieved and accountabilities are clarified.

Finally, two system-wide goals to improve transitional care planning for complex patients are described below. These goals should continue to be pursued as related work, and are in addition to the nine practices that are the focus of this guide.

Background

A key focus of Health Links is to provide better care for the top one to five percent of the population whose needs represent the majority of health care spending.¹ Many of these individuals have complex and/or multiple chronic conditions and would benefit from improved coordination of care and better supports when transitioning from one part of the health care system to another. While this document is specifically designed for use by Health Links, the principles and practices are applicable and beneficial for all patients, at any transition of care.

“Health Links will encourage greater collaboration between existing local health care providers, including family care providers, specialists, hospitals, long-term care, home care and other community supports.”

– Ministry of Health & Long-Term Care, Backgrounder announcing Health Links, December 2012

Supporting Health Links

Health Quality Ontario (HQO) is supporting the implementation of Health Links by partnering with health organizations and researchers to facilitate the widespread adoption of clinical and organizational practices that will achieve the goal of long-term, transformative change in Ontario’s health system.

In May 2013, the Transformation Secretariat of the Ministry of Health and Long Term Care (MOHLTC) asked Health Quality Ontario (HQO) to start a consensus building process aimed at improving and standardizing approaches to transitional care planning.²

Purpose of the Guide

This document is one of many resources intended to provide guidance to Health Link teams. The guide will facilitate the adoption of a consistent approach to transitional care planning for complex patients. It is meant to complement other publications, resources, activities and supports provided by HQO, the ministry, and others, e.g., *The Registered Nurses Association of Ontario Clinical Practice Guidelines for Transitions in Care* (expected release 2014).

The proposed principles and approaches in this guide build on best practice evidence and experiences, as well as information that was compiled in the HQO bestPATH *Transitions in Care* Improvement Package. The ultimate goal in profiling these standards is to guide Health Service Providers (HSPs) in the adoption of a common approach to discharge planning that will facilitate smoother transitions of care between HSPs to improve care for complex patients.

It is important to acknowledge that a number of HSPs and organizations have achieved many of the approaches in this guide. Others are in the process of implementing reforms consistent with these approaches and/or are providing leadership in developing new practices. Some of these practices have been described in documents recently released by the Ontario Hospital Association and HQO.³

¹ The definition and identification of complex patients will vary at the local level but might include, for example, a person with severe heart failure and chronic obstructive pulmonary disease who has early dementia. [Learn more here.](#)

² The term “discharge planning” is strongly linked to the concepts of coordination of care and transition planning. Learn more by reading bestPATH’s [Transitions of Care Improvement Package](#)

³ Ontario Hospital Association (Spring 2013). *Achieving Patient Experience Excellence in Ontario: An Idea Book*. Retrieved from: <http://www.oha.com/CurrentIssues/keyinitiatives/Patient%20Experience/Documents/Final%20-%20Idea%20book.pdf>

Why Transitional Care Planning?

“Recent Ontario data shows that only 59% of hospital patients knew which danger signs to watch for after going home from hospital. 80% knew whom to call if they needed assistance, and only 52% knew when to resume their usual activities.”

- Health Quality Ontario, *Quality Monitor*, 2012

Studies have found that improvements in hospital discharge planning can dramatically improve outcomes for patients as they move to the next level of care. Although discharge planning is a significant part of the overall care plan, there is a surprising lack of consistency in both the process and quality of transitional care planning and documentation across the health care system. In fact, transitional care planning varies from hospital to hospital, across other parts of the care continuum, and often within organizations as well.

While variation will continue to exist in Health Links in every region, they all have a common set of goals that include:

1. A focus on patient-centred care with strong mechanisms in place for the patient/family voice to be heard.
2. A commitment to build on existing delivery organizations and leverage current capacity and best practices.
3. Representation across sectors with joint accountability for attainment of results.
4. Common targets and metrics to support implementation and evaluation.

Improving transitional care planning is a critical lever to achieving these goals and ensuring that patients move smoothly from one part of the care continuum to another; whether patients are discharged home from hospital, referred to an outpatient/ambulatory care program, or transferred to a rehabilitation facility or to another health care setting.

“A good discharge plan improves patient satisfaction and prevents readmissions.”

- Agency for Health Care Research & Quality

Embracing a Common Approach to Transitional Care Planning

The practices outlined in this guide provide a starting point for discussions about what should be included in a common approach to transitional care planning across Health Links. Standardizing approaches to transitional care planning processes across the care continuum and across Health Links is important, as it will:

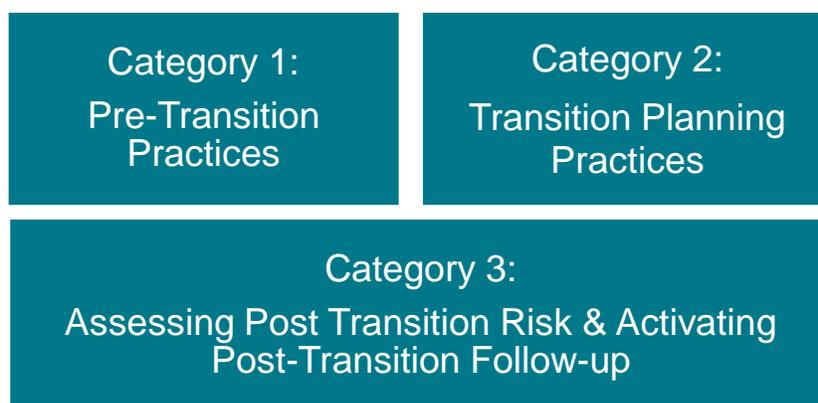
- a) Promote high quality and safe care across the health care continuum
- b) Promote early identification and assessment of patients requiring assistance with planning for discharge
- c) Facilitate collaboration with the patient/substitute decision-maker, family and health care team, including the primary care provider, to facilitate transitional care planning
- d) Recommend options for the continuing care of the patient and refer to other levels of care (accommodation), programs or services that meet the patient's assessed needs and preferences
- e) Foster relationships with community agencies and care facilities to improve coordination of care, address gaps in service delivery and improve transition planning
- f) Provide support and encouragement to patients and families during the stages of assessment and transition
- g) Optimize the appropriate use of health system resources by delivering appropriate care in the right place at the right time⁴

“Discharge planning is a concept fundamental to quality patient care and healthcare system sustainability and it is reasonable to expect a common industry standard.”

– Toronto Central LHIN Discharge Planning Task Force, August 2011

The practices proposed represent a distillation of some of the common themes found in related literature, as well as in the many practical handbooks that have been developed in other jurisdictions to improve transition practices.⁵ Many were identified based on previous work undertaken by HQO, which built on research and knowledge about ‘leading practices’ related to transitional care planning in Ontario and other jurisdictions.

There are nine practices which are intended to be adopted as a ‘package’. The practices are divided into the following three categories:



Each practice includes a brief description of ideas for implementation that build on recurrent themes and approaches described in relevant literature and are being used in current practice. There are some

⁴ Adapted from goals outlined in the Canadian Association of Discharge Planning and Continuity of Care (CADPACC): Guidelines and Standards for Discharge Planning Coordinators, May 1995.

⁵ An additional literature review was also undertaken to supplement and validate earlier findings. Search terms included “discharge planning,” “best practices in discharge planning,” “transition planning,” “best practices in transition planning.” Appendix A includes a list of some of the documents identified through this search.

documentation and scoring tools (provided within the appendices) that have been used and/or are currently being tested that may be helpful to implementation.

Underlying Principles Supporting the Adoption of a Common Approach to Transitional Care Planning Across Health Links

The practices are underpinned by the following principles, which articulate a commitment shared among Health Links to improve transitions of care between HSPs and across the care continuum:

1. Practices and approaches to transitional care planning will be patient-centred
2. A commitment to optimize high quality care, patient safety, and the appropriate use of system resources (e.g., minimizing readmissions and emergency room [ER] visits)
3. Transition planning from a hospital will be initiated upon admission and is an iterative process that will continue throughout the patient's service provision with the goal of discharging the patient to a level of care and setting that promotes their ability to achieve the highest possible level of functioning
4. Transitional care planning will be culturally sensitive and done in a dignified and holistic manner (i.e., include medical, physical, emotional, spiritual, and social needs as identified by the patient)
5. Universal principles of health literacy will be applied and will include standard processes for assessing and documenting the learning needs of patients/caregivers.⁶ The method of teach back being employed with patients/substitute decision-makers and caregivers preparing for care transitions should be considered⁷
6. A commitment to work toward adoption of these practices to ensure that every patient receives care according to leading practices as they relate to:
 - Pre-Transition
 - Transition Planning
 - Assessing Post-Transition Risk & Activating Post-Transition Follow Up
7. Adoption of policies and practices in all hospitals (i.e., acute, rehabilitation, complex continuing care), community –based agencies (including CCACs), and long-term care will ensure that the philosophy of transitional care planning is reflected in:
 - Care policies and practices (e.g., admission policies, discharge policies, Alternate Level of Care (ALC) policies)
 - Operating and emergency preparedness procedures
 - Recruitment, education and promotion of staff
 - Strategic/operational planning and evaluation
 - Senior management oversight and reporting
8. Recognition of the integral role played by all HSPs in the facilitation of transitional care planning as part of coordinated and collaborative care planning, across the health care continuum
9. A willingness to measure performance against a common set of indicators to track progress in adoption of the practices over time

⁶ For example, written materials should be reader-friendly (i.e., plain language, larger font, short sentences, short paragraphs, no medical jargon, lots of white space, use visual aids)

⁷ Teach back is part of an overall strategy to strengthen health literacy. It involves patients (or their families/caregivers) in conveying an understanding of health services, care, procedures or instructions to patients (or their families/caregivers) via verbal and non-verbal means, and ensuring that they are able to communicate this information to other care providers.

Best Practice Goals and Change Concepts

Category 1: Pre-Transition Practices

Overarching Goals

- To include patients/families as partners in transitional care planning
- To ensure that individualized care plans (including specific care goals informed by the patients/ caregivers) are developed and shared on admission amongst the patients' team and used to build an individualized comprehensive transition plan

“Individualized pre-discharge planning should be a multi-component intervention, including some combination of the following: patient education component; patient-centred discharge instructions; and coordination/communication with family physicians and other appropriate community-based services.”

- Ontario Health Technology Advisory Committee (OHTAC), April 2013

Proposed Practices

Each Health Link should adopt the following:

Practice	Description/Ideas for Change
<p>1) Pre-transition planning is incorporated as a standard of care for complex patients admitted to a health care facility</p>	<p>Goals of pre-transition planning should be focused on:</p> <ul style="list-style-type: none"> ▪ Proactively identifying ongoing care needs and identifying and mitigating possible gaps in care related to transitions ▪ Identifying available resources (human, educational etc.) needed to support transitional care planning ▪ Ensuring patients/caregivers understand the medical information/ precautions for their conditions ▪ Ensuring patients receive consistent messaging from all HSPs. ▪ Improving coordination/communication with the patient’s primary care provider(s)
<p>2) Patients and caregivers are involved as partners in the transitional care planning process</p>	<ul style="list-style-type: none"> ▪ Patients are encouraged and provided the opportunity to make their wishes known ▪ Patients and their family/caregiver(s) are engaged to provide the transitional care planning team with important information to support development of the transition plan ▪ Schedule face-to-face and real time transition conversations with the patient and their family/caregiver(s)
<p>3) Individualized comprehensive assessments and care plans are developed for complex patients on admission</p>	<ul style="list-style-type: none"> ▪ The following information/assessments have been deemed vital to informing the transition process as well as a coordinated care plan and ideally will be initiated immediately upon entering the service. Existing coordinated care plans for Health Link patients should both inform this episodic plan as well as be adapted for the patient’s current status. Please note that each Health Link will need to define the process of data collection including information technology and human resources ▪ Information/assessments include: Clinical status and prescribed interventions; social status and support network; cognitive and psychological status; clinical functional status; environmental factors; existing advanced directives; ability to cope/quality of life; healthcare goals and preferences; cultural values and beliefs; preferred language of communication

	<ul style="list-style-type: none">▪ Assess and document the individual's level of health literacy (i.e., the person's ability to understand written or verbal information relating to their health and healthcare needs); include the person's level of health literacy regarding their transitional care plan(s)▪ Assess the capabilities and willingness of the individual and their caregiver(s) in providing post-transition care▪ Assess and document the individual's post-facility care preferences and needs (e.g., living arrangement preferences, social and cultural supports, clinical status and prescribed interventions, and diet)▪ Assess and document the individual's risk of readmission using a standardized screening tool (e.g., LACE index) and include this information in the care and transition plan(s)▪ Create Best Possible Medication History (BPMH) and reconcile medications; incorporate into transition plans▪ Ensure that the primary care provider (or their delegate, as appropriate within their scope of practice) and the CCAC (if the patient is an existing client) are notified immediately upon the decision to admit. If the patient is not a CCAC client but will need a CCAC referral, notify the CCAC as soon as this decision is made
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Category 2: Transition Planning Practices

Overarching Goals

- To support Health Links establish standardized processes for medication reconciliation to ensure that patients understand how to manage their medications
- To improve coordination/communication with patients and their families/caregivers, primary care providers and other appropriate HSPs.

Proposed Practices

Each Health Link should promote the following:

Practice	Description/Ideas for Change
<p>4) Individualized transitional care plans are developed on admission for patients with complex needs</p>	<p>Transitional care plans should be developed using a standardized approach. The plan should:</p> <ul style="list-style-type: none"> ▪ Include essential education on health conditions, medications and instructions to the patient ▪ Be easy to read (i.e. use plain language) ▪ Involve patients and families/caregivers in the development of the plan ▪ Include a CCAC referral as appropriate <p><i>At time of transition:</i></p> <ul style="list-style-type: none"> ▪ Real time transition conversations with the patient and their family/caregiver(s) should occur ▪ Provide a hard copy of the individualized transition plan to the patient and their family/caregiver at the time of transition ▪ (If hospital): Confirm CCAC service is activated ▪ Provide documentation on individualized care and transition plans to the primary care provider and most responsible provider(s) at the next stage of care ▪ Provide an updated post-transition medication regimen; review with the patient and their family/caregiver(s) at the time of transition. ▪ Confirm patient's (and/or their family/caregivers') comprehension of the information discussed (document level of understanding of the patient) ▪ Support patients and their families/caregivers in coordinating and/or activating post-transition resources, as required, based on earlier assessment of needs
<p>5) Protocols are established to ensure medication reconciliation at key transition points</p>	<ul style="list-style-type: none"> ▪ Medication reconciliation refers to the process of obtaining a complete and accurate list of each patient's current medications (including name, dosage, frequency, etc.) and using that list when writing transitional medication orders⁸ <p><i>Complete medication reconciliation at care transitions</i></p> <ul style="list-style-type: none"> ▪ Include the patient and their family/caregiver, pharmacists from the individual's local pharmacy and, where possible the primary care team to ensure a complete and accurate medication history ▪ Assess the patient's knowledge of medications on transition ▪ Reconcile medications. Use BPMH to create and/or compare to other transitional care plans ▪ Reconcile medications prior to discharge and include reconciled medication lists as part of the discharge summary which is given to

⁸ According to *Enhancing the Continuum of Care: Report of the Avoidable Hospitalization Advisory Panel, November 2011*: "The ultimate goal of medication reconciliation is to prevent adverse drug events at all interfaces of care, for all patients."

	<p>all of the health service providers who will provide care following discharge</p> <p>Provision of a post-transition medication list to patient/caregiver</p> <ul style="list-style-type: none"> ▪ Medication list provided to the patient/caregiver using non-medical language, clearly describing which medications have been added, changed or discontinued as compared to the BPMH taken on admission. Consider checklists or non-written cues (use of symbols or pictograms) to help the patient take their medications as prescribed ▪ Key information about medications to be taken post transition, including: purpose of medication; dosage of medication; when to take medication; how to take medication; and how to obtain medication <p>Assessment of the need for post-transition medication reconciliation and review with the patient and their family/caregiver at time of transition</p> <ul style="list-style-type: none"> ▪ Include recommended schedule for next medication reconciliation as required and include in the transition summary
<p>6) Families/caregivers are provided with information and resources to support their transition</p>	<p>At a minimum the patient and their family should be provided with a patient-friendly transition plan that includes:</p> <ul style="list-style-type: none"> ▪ An instruction sheet including advice on when “normal” activities can be resumed ▪ A reconciled medication list ▪ Dates for follow up appointments and any follow up tests. ▪ A name, position and contact number of the individual involved in their transition plan who can be contacted after transition <p>Where appropriate/required, additional information should be provided regarding</p> <ul style="list-style-type: none"> ▪ When to change bandages/ dressings ▪ What can and cannot be consumed ▪ Any special equipment or supplies needed (e.g., walker, oxygen) and how access will be facilitated <p>Verify, using teach back, that the person understands:</p> <ul style="list-style-type: none"> ▪ How to recognize worsening symptoms ▪ When and how to seek help, and from whom ▪ When, how and why to take the medications, and conduct other elements of the self-care plan ▪ Scheduled appointments (when, where, why and with whom)

Category 3: Assessing Post-Transition Risk & Activating Post-Transition Follow-Up

Overarching Goals

- To ensure that patients at high risk for readmission and ER visits are proactively identified
- To ensure that a care plan is individualized in preparation for successful transition
- To ensure that transition plans are in place and followed so that the patient's care is coordinated between one caregiver and another
- To ensure that every member of the care team (including personal support workers, nurses, etc.) can easily collaborate with patient/family and care team members on a real-time basis

Proposed Practices

Each Health Link should adopt the following:

Practice	Description/Ideas for Change
<p>7) Standardized risk assessment tools are used to assess and stratify complex patients</p>	<ul style="list-style-type: none"> ▪ Patients with complex needs should be assessed and stratified as close as possible to admission so that issues can be addressed prior to transition and/or arranged post transition based on their risk level for readmission to the current setting ▪ Each Health Link should agree on adoption/utilization of a standard risk tool that will be used by organizations within their network to identify individuals who are at risk for readmission to hospital post transition. <i>Note: It is recommended that adoption of a standardized tool build on existing screening tools that have been developed by organizations working on the risk of patient readmission to acute care post discharge⁹</i> ▪ Each patient should be assigned targeted interventions based on their risks
<p>8) Appointments are booked with the patient's primary care provider</p>	<ul style="list-style-type: none"> ▪ Each HSP/health care organization should put in place standardized processes to ensure that prior to transition a follow up appointment(s) is scheduled for patients with their primary care provider post transition ▪ For hospitals: Ideally, a conversation should take place between the most responsible physician (MRP) in the facility and the patient's primary care provider in the community with a focus on the following goals: to support a smooth transition in the transfer of care; to clarify the reason for admission; and to provide advice on the recommended follow up care/monitoring required post transition
<p>9) Complex patients receive a follow up phone call within 48 hours of discharge from hospital</p>	<ul style="list-style-type: none"> ▪ Calls should be made by a community and/or hospital care provider using a standard survey with a focus on the following goals: to monitor patient progress; to establish community networks for meeting patient needs; to enhance patient education and self-management training; to provide follow up/reinforcement of the transition plan; and to include the CCAC referral process through the Resource Matching and Referral Initiative

⁹ See [Appendix B](#) for an example of a standardized assessment tool.

Disseminating & Implementing the Common Practices

A key success factor in implementing a common approach to transitional care planning will be to ensure that the leadership of each Health Link and LHIN promotes 'buy-in' amongst HSPs, administrators, and patients/caregivers with respect to these practices. Another important issue is the need to clarify and detail the accountabilities of all those involved in transitional care planning and processes.

It is recommended that each Health Link establish a mechanism (e.g., working group, committee) to provide a focal point for these activities and oversight to support implementation. This group should also focus on developing strategies to advance the adoption of the practices. For example:

- Establishing and nurturing the role of champions within organizations/Health Links who are leading initiatives to standardize approaches related to transitional care planning
- Enhancing awareness and conducting widespread communications on how the adoption of a common approach to transitional care planning will support patient, organizational and system-wide goals (e.g., improvements in patient care, reduction in readmission rates, length of stay, ALC)

Additional Goals

In addition to work that will be undertaken to endorse the practices in this guide, there is also interest in advancing two additional, system-wide goals to improve transitional care planning for complex patients:

1) Adoption of a standardized discharge summary template for use among all health care organizations that perform discharge planning.¹⁰

In early 2013, the GTA Health Information Collaborative CEO group approved the template design of a standardized discharge summary and the implementation of the template across the Toronto Central LHIN sites under the leadership of St. Michael's Hospital.¹¹ The advantages of a standardized discharge summary template are summarized in the table below:

Advantages of a standardized discharge summary	
For patients	<ul style="list-style-type: none"> ▪ Fewer adverse health events as a result of increased communication between care providers ▪ Seamless transitions in care ▪ More knowledge about important discharge aspects
For organizations	<ul style="list-style-type: none"> ▪ Supported and improved communication and coordination between and within the community/primary care providers, hospital, post-discharge care providers and patients and families ▪ Improved methods to support care transition ▪ Improved continuity and coordination of care, and reduced medical errors ▪ Increased patient satisfaction and reduced hospital readmissions and patient complications ▪ Reduced requests for additional information
For the health care system	<ul style="list-style-type: none"> ▪ Improved health outcomes of complex patients with high cost care needs ▪ Appropriate transitions in care focusing on patient experience ▪ Reduced hospital re-admission rates and visits to ER ▪ Lowered healthcare costs

2) System-wide implementation of designated supports for complex patients in the post-transition follow-up period.

Implementation of this concept may include the introduction of transition coordinators/coaches and/or greater clarity regarding the roles and accountabilities of organizations in managing transitions and coordination of care.

¹⁰ See [Appendix C](#) for examples of discharge summary templates

¹¹ St. Michael's Hospital. *Backgrounder: Standardized Discharge Summary Template Development and TC LHIN Implementation*. (PowerPoint presentation [unpublished], 2013).

Conclusion

Effective transitional care planning should be a routine part of health care delivery. It should also be part of an overall health care plan for each patient, which spans not only admission to a facility, but also their overall care (which occurs primarily in the community).¹²

This document is intended to promote the standardization of transition practices within and across Health Links and is designed to be a tool for improving transition planning and the coordination of care for complex patients.

For more information on how to implement effective transitional care planning, please see the appendices, or visit www.hqontario.ca

¹² Department of Veterans' Affairs (2005). *Discharge Planning: Resource Kit*. Australia. Retrieved from: http://www.dva.gov.au/service_providers/dental_allied/discharge_planners/Documents/dprk.pdf

Tools & Resources

Health Quality Ontario tools and resources:

bestPATH - Transitions of Care: Evidence Informed Improvement Package

This document was developed as a tool to introduce examples of change concepts designed to improve the transitioning of individuals between care providers and environments. [Download the Improvement Package.](#)

Discharge Planning in Chronic Conditions: An Evidence-Based Analysis. Ontario Health Technology Assessment Series. 2013 September; 13 (4):1–72.

This report summarizes the results of a standard systematic literature search for studies published from January 1, 2004 until December 31, 2011. The objective of the review was to determine if discharge planning is effective at reducing health resource utilization and improving outcomes compared with standard care alone. [Download the full report.](#)

Optimizing Chronic Disease Management in the Community (Outpatient) Setting (OCDM): An Evidentiary Framework. Ontario Health Technology Assessment Series. 2013 September; 13(3): 1-78

This analysis sets out to answer the following question: What evidence-based community services are effective and cost-effective for optimizing chronic disease management among adults? The focus was on adults with at least one of the following high-burden, chronic conditions: chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), atrial fibrillation, heart failure, stroke, diabetes or chronic wounds. [Download the full report.](#)

Quality Compass

An online, comprehensive evidence-informed searchable tool centered around priority health care topics with a focus on best practices, change ideas linked with indicators, targets and measures, tools and resources to bridge gaps in care and improve the uptake of best practices. [Visit Quality Compass](#)

Ministry of Health & Long-Term Care resource:

Enhancing the Continuum of Care: Report of the Avoidable Hospitalization Advisory Panel, November 2011.

In September 2010, the ministry convened an Avoidable Hospitalization (AH) Advisory Panel and named Dr. G. Ross Baker as the chair. The Panel had a mandate to identify system-wide AH best practice guidance, form and content of an AH improvement practices inventory, and measures and an evaluation framework for AH initiatives. Dr. Baker and his Panel have completed their work and submitted their report, *Enhancing the Continuum of Care*, to the ministry. [Download the full report.](#)

Ontario Hospital Association (OHA) resource:

Achieving Patient Experience Excellence in Ontario: An Idea Book (Spring 2013)

The Idea Book highlights outstanding improvement projects and develops case studies to help other hospitals achieve similar successes. The Idea Book is about engagement on three levels: the community of care (LHINs, CACCs), hospital staff, and the patients and their families. The idea book was developed with the support of the Ministry of Health & Long-Term Care and supports the notion of delivering a better patient experience by inspiring others to undertake similar projects. It is also part of the OHA's continued commitment to supporting hospitals improve the patient experience. [Download the Idea Book.](#)

Other tools and resources:

The Department of Health (UK) Discharge Summary Implementation Toolkit

In August 2010, the United Kingdom's Clinical Data Standards Assurance program began a project to deliver a national, clinically-assured electronic Discharge Summary (DS), which focuses on the DS which is sent from an acute medical/surgical team to the GP within 24 hours of the patient being discharged. This DS was intended to be structured, standardized and generic thus, having the ability to be sent electronically from any acute hospital electronic health record (EHR) system. A toolkit was produced to facilitate the implementation of this work in a consistent manner. The toolkit contains case studies and short video clips from organizations who successfully implemented the 24 hour Discharge Summary. [Download the toolkit.](#)

Canadian Foundation for Healthcare Improvement: Improving Treatment for Seniors in Acute Care

Recent work supported by the Canadian Foundation for Healthcare Improvement focuses on an early intervention strategy that identifies five key areas of patient care for seniors that need to occur within the first 48 hours of admission. Results of the pilot project suggest that this process will result in quicker recovery and discharge of older patients from the hospital. [Download a briefing on this work.](#)

The RARE (Reducing Avoidable Readmissions Effectively) Campaign

This initiative focuses on engaging hospitals and care providers in Minnesota (across the continuum of care) to prevent 6,000 avoidable hospital readmissions within 30 days of hospital discharge between July 1, 2011 and December 31, 2013. The RARE Campaign builds upon and expands work that has been going on for several years by many hospitals, medical groups, health plans and the Operating, Supporting and Community Partners. The campaign focuses on five key areas:

- [Comprehensive discharge planning](#)
- [Medication management](#)
- [Patient and family engagement](#)
- [Transition care support](#)
- [Transition communications](#)

Re-Engineered Discharge (RED) Toolkit. Agency for Healthcare Research and Quality

The Project RED (Re-Engineered Discharge) intervention is a patient-centered, standardized approach to discharge planning. Initially developed through research conducted by Dr. Brian Jack of the Boston University Medical Center and funded by the Agency for Healthcare Research and Quality (AHRQ), Project RED improves patient preparedness for self-care and reduces preventable readmissions. The AHRQ developed the RED Toolkit to help hospitals reduce readmission rates. [Download the toolkit.](#)

The S.M.A.R.T Discharge Protocol

SMART Discharge protocol is a framework that can be applied to discharge processes to ensure key areas are always addressed during hospitalization and at discharge, which can reduce readmissions. SMART is an acronym for: **S**ymptoms, **M**edications, **A**ppointments, **R**esults, **T**alk. [Download the SMART Discharge Protocol Self-Learning Packet.](#)

Appendices

Listed below are some of the tools that are currently being tested in the field and within other jurisdictions. The intent here is to provide a non-exhaustive set of examples from which to choose. There are also other tools that are currently being tested or in use that are not included in this guide. The primary focus of this guide is to establish common standards for discharge planning and is not intended to be a toolkit.

Please note that each example listed below will require discussion, testing and adaptation to suit the specific and unique approach of each Health Link.

A. Risk Assessment Tools

A1. Ottawa Hospital Research Institute (OHRI): LACE Index Scoring Tool for Risk Assessment of Death and Readmission

Status: Several Hospitals Across the province are using this tool.

Note that there are other risk assessments in the environment and this is just one example.

**Ottawa Hospital Research Institute
LACE Index Scoring Tool for Risk Assessment of Death and Readmission**

Step 1. Length of Stay
Length of stay (including day of admission and discharge): _____ days

Length of stay (days)	Score (circle as appropriate)
1	1
2	2
3	3
4-6	4
7-13	5
14 or more	7

} → [L]

Step 2. Acuity of Admission
Was the patient admitted to hospital via the emergency department?
If yes, enter "3" in Box A, otherwise enter "0" in Box A

[A]

Step 3. Comorbidities

Condition (definitions and notes on reverse)	Score (circle as appropriate)
Previous myocardial infarction	+1
Cerebrovascular disease	+1
Peripheral vascular disease	+1
Diabetes without complications	+1
Congestive heart failure	+2
Diabetes with end organ damage	+2
Chronic pulmonary disease	+2
Mild liver disease	+2
Any tumor (including lymphoma or leukemia)	+2
Dementia	+3
Connective tissue disease	+3
AIDS	+4
Moderate or severe liver disease	+4
Metastatic solid tumor	+6
TOTAL	

If the TOTAL score is between 0 and 3 enter the score into Box C.
If the score is 4 or higher, enter 5 into Box C

[C]

Step 4. Emergency department visits
How many times has the patient visited an emergency department in the six months prior to admission (not including the emergency department visit immediately preceding the current admission)? _____
Enter this number or 4 (whichever is smaller) in Box E

[E]

Add numbers in Box L, Box A, Box C, Box E to generate LACE score and enter into box below. If the patient has a LACE score that is greater than or equal to 10, the patient can be referred to the virtual ward. (Note: A *virtual ward* uses the systems and staffing of hospital care, but without the physical building: staff provide preventative care for patients in their own homes. If your hospital does not support a virtual ward, proceed to treat patient as a high risk individual.)

[LACE]

Shared with permission from Carl van Walraven (lead author) on July 3, 2012.

A2. Blaylock Discharge Planning Risk Assessment Screen

 Blaylock Discharge Planning Risk Assessment Screen			PATIENT ID _____			
Circle all that apply and total. Refer to scoring index for recommendations regarding discharge planning.						
Age	55 years or less	0	Functional Status	Independent in activities of daily living and instrumental activities of daily living	0	
	56-64 years	1		<i>Dependent in:</i>		
	65-79 years	2		Eating/Feeding	1	
	80+ years	3		Bathing/Grooming	1	
Living Situation/Social Support	Lives only with spouse	0		Toileting	1	
	Lives with family	1		Transferring	1	
	Lives alone with family support	2		Incontinent of bowel function	1	
	Lives alone with friend's support	3		Incontinent of bladder function	1	
	Lives alone with no support	4		Meal Preparation	1	
	Nursing home/residential care	5		Responsible for own medication administration	1	
Number of Previous Admissions/ Emergency Room Visits	None in the last 3 months	0		Handling own finances	1	
	One in the last 3 months	1		Grocery Shopping	1	
	Two in the last 3 months	2		Transportation	1	
	More than two in the last 3 months	3				
Number of Active Medical Problems	Up to three medical problems	0		Behaviour Pattern	Appropriate	0
	Three to five medical problems	1			Wandering	1
	More than five medical problems	2	Agitated		1	
			Confused		1	
Number of Drugs	Fewer than three drugs	0	Other	1		
	Three to five drugs	1	Mobility	Ambulatory	0	
	More than five drugs	2		Ambulatory with mechanical assistance	1	
		Ambulatory with human assistance		2		
Cognition	Oriented	0		Nonambulatory	3	
	Disoriented to some spheres (person, place, self, time) some of the time	1	Sensory Deficits	None	0	
	Disoriented to some spheres (person, place, self, time) all of the time	2		Visual or hearing deficits	1	
	Disoriented to all spheres (person, place, self, time) and some of the time	3		Visual and hearing deficits	2	
	Disoriented to all spheres (person, place, self, time) all of the time	4				
	Comatose	5				
Total Score: _____ Signature: _____ Date: _____						
SCORING INDEX		RECOMMENDED CONSULTS				
0-10	At risk for home care services	Physician Order NOT Required		Physician Order Required		
11-19	At risk for discharge planning	<input type="checkbox"/> Social Work	<input type="checkbox"/> Wound Care	<input type="checkbox"/> Physio <input type="checkbox"/> Dietitian		
>20	At risk for placement other than home	<input type="checkbox"/> CCAC Case Mgr	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Speech		
		<input type="checkbox"/> Geriatric CNS	<input type="checkbox"/> Respiratory T.	<input type="checkbox"/> Occupational Therapist		
REQUIRED ACTIONS						
Enter score into Meditech "Blaylock D/C Risk Screen". NOTE: An alert will be sent to CCAC Case Manager for all patients scoring 11+ who were not admitted from LTC						
For consults not requiring a physician order, enter consult request into Meditech Order Entry and put "✓" on whiteboard						
For consults requiring physician order, complete a green communication form to request physician order and put "A" on whiteboard						
Rev Oct 2011		Blaylock A. & Cason C.L. 1992				

CCAC Case Manager Enter consult in Meditech	<ul style="list-style-type: none"> - If Blaylock Score is 11+ and patient not from LTC, enter a CCAC Alert into Meditech - Services and supports required to transition home - Long Term Care applications - Arrangements for home equipment and supplies
Geriatric Clinical Nurse Specialist (CNS) Enter consult in Meditech	<ul style="list-style-type: none"> - Comprehensive gerontology focused assessments and recommendations - Promotion of cognitive and physical functioning
Nurse	<ul style="list-style-type: none"> - Promotes health and the assessment of, the provision of, care for, and the treatment of, health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function for assigned patients. - Facilitates and supports processes that promote holistic approaches that assess the patient's medical, functional, cultural, emotional, and psycho-social needs from admission to discharge.
Occupational Therapist (OT) Request Order	<ul style="list-style-type: none"> - Mobility and activities of daily living (ADLs) independence including home safety, discharge readiness and home accessibility - Physical, cognitive and/or perceptual impairment - Wound care consultation re: therapeutic mattresses/surfaces - Hospital/home equipment needs (recommendation and provision for), including: wheelchairs, walkers, assistive devices - Energy conservation/work simplification education - Care planning/discharge planning consultation including post acute care referral
Physiotherapist (PT) Request Order	<ul style="list-style-type: none"> - Mobility/physical impairment including range of motion, strength, mobility/transfers, cardio-respiratory function - Care planning/discharge planning consultation including post acute care referral
Pharmacist Enter consult into Meditech	<ul style="list-style-type: none"> - General assessment/consultation regarding medications - Other consultations related to pain/PCA, self medication, teaching, TPN, allergies, medication reconciliation, Medication Administration Record (MAR), patient leave, dysphagia
Registered Dietitian (RD) Request Order	<ul style="list-style-type: none"> - Nutritional assessment, care planning, monitoring, education and counselling - Writes orders/recommendations for the therapeutic diets, supplements, Enteral/Parenteral nutrition, medications (i.e. insulin, phosphate binders, multivitamins etc) - Completes nutrition related application forms such as Ontario Disability Support Program (ODSP) Special Diet Application form and Ontario Drug Benefit (ODB)
Respiratory Therapist (RT) Request Order	<ul style="list-style-type: none"> - Respiratory function including inhaled pharmacotherapy, secretion management, dyspnea management - Home oxygen assessments from chronic (ABG) and palliative patient discharges - Titration of oxygen therapy/determination of appropriate resting and exertion oxygen requirements - Arranging Pulmonary function Testing (PFT), sleep studies, CPAP/BIPAP therapy - patient Education regarding Respiratory disease management - Assist with obtaining difficult oximetry
Social Worker (SW) Enter Consult into Meditech	<ul style="list-style-type: none"> - Psychological and emotional well being related to adjustment to changes in health status - Patient/family advocacy - Bio-Psychosocial assessment - Patient care and discharge planning consultation
Speech Language Pathologist (SLP) Request Order	<ul style="list-style-type: none"> - Communication impairment including expressive language, comprehension, speech, voice, reading and/or writing - Cognitive skills affecting communication such as memory, attention and reasoning skills - Dysphagia Team - swallowing impairment (together with Occupational Therapy, Dietician)

B. Discharge Screening

Complex Discharge Screening Tool: Emergency Department to Homecare

There is a subset of individuals who enter hospital for an acute care episode that are at risk of having a complex discharge, and are therefore at risk of staying in hospital and becoming ALC. Identifying patients at risk ensures earlier discussions between health care team members, CCAC, clients and their family to ensure that everyone is working together to facilitate a return home with appropriate supports once acute care is no longer required.

The process for identifying these patients is now supported through the use of the Complex Discharge Screening Tool that was developed for use within the South West. The Complex Discharge Screening Tool was developed based on a comprehensive review of several screening tools currently in use across the province used to identify clients at risk of complex discharge. In almost all other Home First implementations across the province, some form of a screening tool is used. In the South West, the tool is administered by hospital staff at the time of admission to hospital, and if positive, generates an automatic electronic referral for a CCAC Assessment. Extensive analysis of the tool and validation of the accuracy of the results have been completed to ensure it is appropriately identifying complex clients.¹³


COMPLEX DISCHARGE SCREENING TOOL
Emergency Department

Is this client struggling at home and / or is in need of CCAC support

No, patient does not foreseeably require CCAC support

Yes, continue with the screening tool.

1. Inadequate supports or caregiver burnout/ fatigue? Yes No

2. Difficulty walking/transferring with current supports or has had a/fall in the last month? Yes No

3. Frequent visits to the ED or frequent admissions to Hospital? Yes No

4. Patient is unable to complete basic daily tasks without assistance (ADL's)? Yes No

5. Other concerns that could delay patient discharge once medically stable. (e.g. social, housing, or safety) Yes No

COMMENTS: _____

Form Completed By (Please Print): _____

Date: _____ Time: _____

Please place form in the Orange basket on the Clerk's desk.

ED CM Pager# 13964

June 18, 2013

¹³ South West Local Health Integration Network (LHIN). *Access to Care: Home First Year in Review 2012*. Retrieved from: http://www.ccac-ont.ca/Upload/sw/General/Home%20First/Home_First_Review_April2013.pdf

C. Discharge Summary Templates

C1. Toronto Central LHIN Standardized Discharge Summary Template

Standardized Discharge Summary Template

Data Elements	Definitions/Explanations
Patient (Demographics)	
Patient name	
Patient Identifier (Medical Record Number)	MRN is the hospital Medical Record Number
Date of Birth (DOB)	
Gender	
Primary Care Provider	
Visit (Encounter)	
Admit date	
Discharge Date	
Discharge Diagnosis	
Most Responsible Health Care Provider name and contact information	The provider who is responsible for the care and treatment of the patient for the majority of the visit.
Completed by (if not completed by MRHCP)	
Date Completed	
Patient Encounter type	Default-Inpatient. (The Discharge Summary Template only applies to encounter type of Inpatient. Inpatient is defined as occupying a designated bed.)
Discharge Disposition	This identifies the location where the patient was discharged to. Eg Home, Home with Support Services, Transfer to Acute Care Institution (named) or Death.
Encounter Location/Org	
Hospital/Service Name	Hospital Name
Hospital/Service Type	Describes the basic type or category of the service delivery location. Eg, Acute Care or Rehab
Alert Indicators	
Allergies (Yes, None known)	If Yes, list all medication allergies and describe reaction.
Course While in Hospital	
Presenting Complaint(s)	
Summary of key results	
Investigations	
Interventions	
Advance directives	
Adverse Events and complications	An event that results in unintended harm to the patient and is related to the care and/or services provided to the patient rather than to the patient's underlying condition.
Diagnosis	
Other Conditions Impacting Hospital Stay	A condition that coexists at the time of admission or develops subsequently and requires treatment beyond the preexisting condition, or increases the length of stay by at least 24 hours or significantly affects the treatment received.
Other Conditions	
Discharge Plan	
All medications at discharge	This is for home medications to be continued, home medications, which have been discontinued, and newly prescribed medications.
Follow-up instructions for patient	Include follow up scheduled by current provider.
Follow-up Plan recommended to be implemented by the receiving provider	
Referrals	These are referrals that have been initiated by the sender.
Copied to with contact information:	

C2: Avoidable Hospitalization Advisory Panel, November 2011

Status: Requires field testing and evaluation

Safe Discharge Practices for Hospital Patients Checklist

	Day 1	Day 2	Day 3	Day 4	D/C	D/C +1	D/C +2	D/C +3	D/C +4	D/C +5	D/C +6	D/C +7	D/C +8	D/C +9	D/C +10
	Admit														
1 Hospital															
a Assess patient to see if they still require hospitalization [M&E]	✓	✓	✓	✓											
2 Primary Care															
a Identify &/or confirm patient has an active primary care physician (PCP) – alert care team if no PCP and/or contact Health Care Connect to begin PCP search [M&E]	✓														
b Contact PCP and notify them of patient's admission, diagnosis and predicted discharge date	✓														
c Book post-discharge primary care follow-up appointment within 7-14 days of discharge [M&E]: • Patient may need to be seen sooner based on risk of readmission (LACE) • Notify PCP pending diagnosis date • PCP can use supplemental billing code e080 if seeing patient following a hospital discharge				✓											
3 Medication Safety															
a Develop best possible medication history (BPMH) and reconcile this to admission's medication orders [M&E]	✓														
b Teach patient how to properly use discharge medications and how these relate to medications they were on prior to admission	✓	✓	✓	✓	✓										
c Reconcile discharge medication order/ prescription with BPMH and medications prescribed while in hospital [M&E]					✓										
4 Follow-up															
a Perform post-discharge follow-up phone call to patient. During call, ask: • Has patient received their new meds (if any)? • Has patient received home care? • Remind patient of upcoming appointments • If necessary, schedule patient and caregiver to come back to facility for education and training															(if needed) ✓
b If necessary, arrange out-patient investigations (lab, radiology, etc.)					✓										
c If necessary, book specialty clinic follow-up appointment					✓										
5 CCAC															
a CCAC shares information, where available, about patient's existing community services	✓	✓	✓	✓											
b Engage CCAC (e.g., bullet rounds) [M&E]	✓	✓	✓	✓	✓										
c If necessary, schedule post-discharge care	✓	✓	✓	✓	✓										
6 Communication															
a Provide patient, community pharmacy, PCP, and formal caregiver (family, LTCH, CCAC) with copy of Discharge Summary Plan/Note, Medication Reconciliation Form and contact information of attending hospital physician and inpatient unit [M&E]					✓										
7 Patient Education															
a Patient performs Teach Back (see Patient Teaching for tips) to clinical team	✓	✓	✓	✓	✓										
b Explain to patient how new medications relate to diagnosis	✓	✓	✓												
d Thoroughly explain discharge summary to patient (use Teach Back if needed)					✓										
e Explain potential symptoms, what to expect while at home and under what circumstances patient should visit ED					✓										

References

- Avoidable Hospitalization Advisory Panel (November 2011). *Enhancing the Continuum of Care: Report of the Avoidable Hospitalization Advisory Panel*. Retrieved from: http://www.health.gov.on.ca/en/common/ministry/publications/reports/baker_2011/baker_2011.pdf
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