Transitions Between Hospital and Home

In the Community Post Hospital Stay: Ensure Discharge Summary Available to Primary Care within 48 hours

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Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up.

Figure 1 is an outline of **innovative practices and evidence-informed best practices** that are designed to improve transitions between hospital and home.

The use of these practices varies significantly across the province. Teams are encouraged to prioritize the implementation of evidence-informed best practices before adoption of the innovative practices outlined in this document. When considering the adoption of innovations, *recommended practices* should be considered first, followed by *promising practices*, and then *emerging practices*.

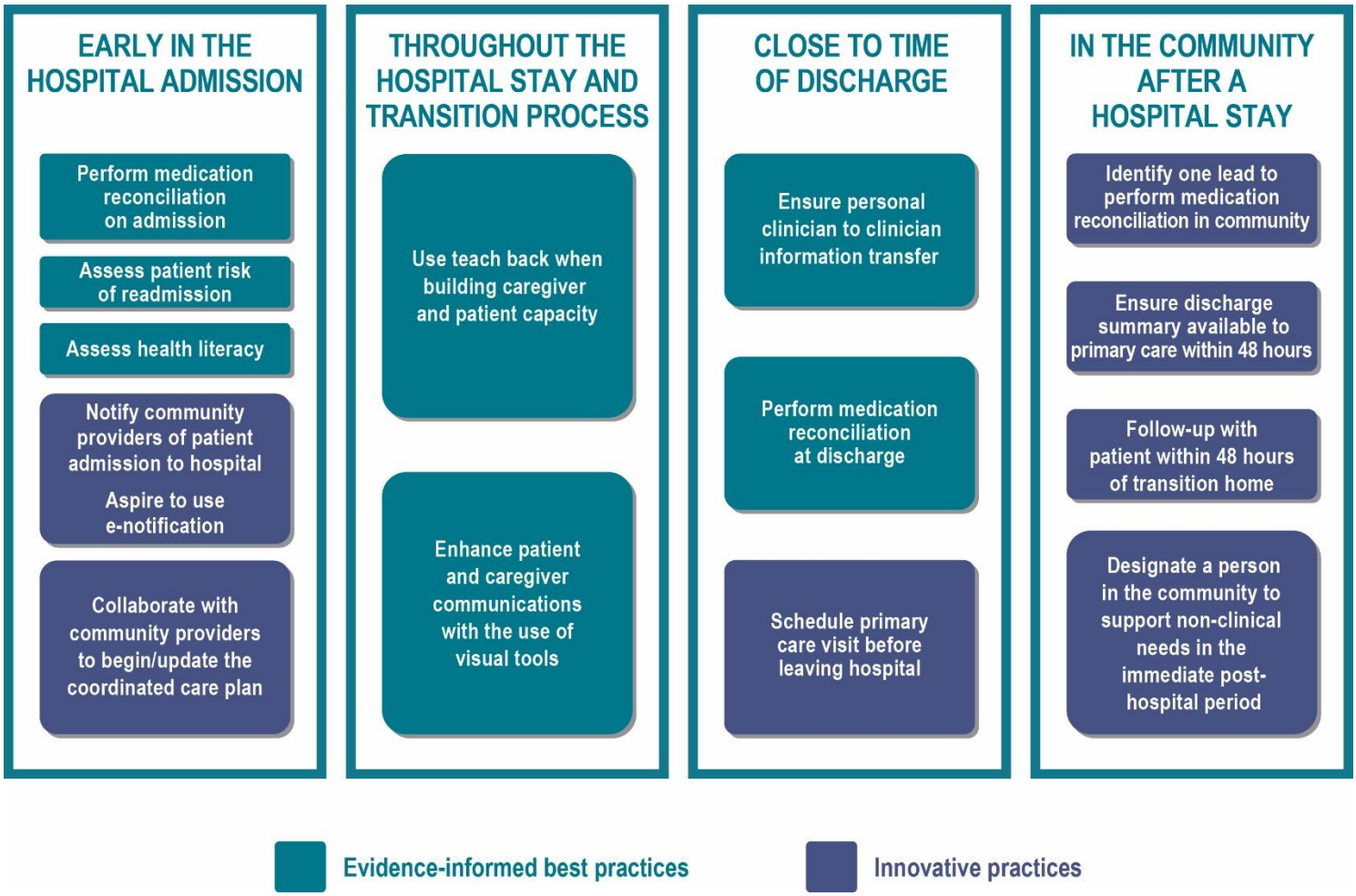

Figure 1: Practices to Improve Transitions Between Hospital and Home

The material for Transitions Between Hospital and Home was developed in collaboration with Health Links and the Clinical Reference Group.

Description of this Innovative Practice

A discharge summary is a written form of communication that generally contains a description of the hospital stay, diagnoses, interventions performed, and recommended action steps. Discharge summaries accompany patients after discharge from hospital and are written for care providers who will provide follow-up care. Created by the most responsible physician (MRP) from the inpatient stay, discharge summaries should be available to the primary care provider (PCP) within 48 hours of hospital discharge. This communication is critical to a patient's transition because it is relied upon to make ongoing clinical recommendations in their care.[1]

Innovative Practice	Innovative Practice Assessment[2]	Clinical Reference Group Endorsement for Spread
Ensure a discharge summary is available to primary care within 48 hours.	PROMISING	Provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (Sept 2017). ❖ This should be implemented in conjunction with the innovative practice to schedule a primary care visit before hospital discharge.

Implementation of the Innovative Practice		
Steps for Implementation	**Tools and Resources**	**Considerations**
1. Create in-hospital processes to have discharge summary completed and sent within 48 hours. A discharge summary from provider-to-provider should be provided within 48 hours of discharge to support communication during the transition from hospital to home. Hospitals should align internal and external processes required to have discharge summary completed and sent within 48 hours. Hospitals should consider hospital policies, procedures and medical by-laws to ensure consistency in practice over the long term. ***2. Primary Care Provider (PCP) alerted of available discharge summary*** Primary Care Providers (PCPs) should be alerted by the hospital to the fact that a discharge summary is available for their patients with multiple conditions and complex care. Some hospitals successfully provide the discharge summary within 48 hours; however, without a	Examples of standard discharge summary templates: • **Toronto Central (TC) LHIN** developed and implemented a Standardized Discharge Summary (SDS) Template in 2013/2014 to facilitate consistency in information sharing between the hospital and PCP (see Appendix A for summary outline). • **Project RED (Re-Engineered Discharge)** is a research group from Boston University Medical Centre that develops and tests strategies to improve the hospital discharge process. Component 11 of their process focuses on expediting transmission of the discharge summary to clinicians accepting	• Developing a practice to have discharge summaries available in a timely manner requires collaboration between hospital and local PCPs. Ideally there would be one standard for obtaining discharge summaries however, due to primary care differences, there may be a need to have several processes to meet PCP needs. • Historically, providers dictate their discharge summaries, the summaries are typed into a letter format, and then the provider "authenticates" the accuracy of the transcribed letter. To ensure PCP receives information as soon as possible, some hospitals provide an early unauthenticated discharge summary and share with the PCP prior to receiving the final authenticated copy. When determining if an unauthenticated

[1] van Walraven C, Seth R, Austin PC, Laupacis A. Effect of Discharge Summary Availability During Post-discharge Visits on Hospital Readmission. J Gen Intern Med. 2002 Mar;17(3):186-192.

[2] *For more information about the Innovative Practices Evaluation Framework assessments, please go to the following link:* *http://www.hqontario.ca/Portals/0/documents/qi/health-links/innovative-practices-evaluation-framework-overview-en.pdf*

Implementation of the Innovative Practice		
Steps for Implementation	**Tools and Resources**	**Considerations**
process to flag the availability of the summary, the PCP may not be aware of the upcoming patient visit nor the discharge summary. Discharge information should also be shared with the patient. The dictated and transcribed note may be shared with the patient/caregiver; however, it may not be the most relevant information to the patient during the transition.[3]	care of the patient (http://www.bu.edu/fammed/projectred/components.html). • **Mississauga Halton LHIN** –The **CCAC** developed the Seamless Transitions: Hospital to Home Guidebook and it includes *My Plan of Care* and *My Story* templates for discharge (http://healthcareathome.ca/mh/en/Documents/SeamlessTransitionsGuidebook.pdf). Implementation example from the field: ○ **South West LHIN- St. Thomas Elgin General Hospital** reported overall percent of discharge summaries sent from hospital to primary care within 48 hours increased from 41% to 87%. The impact of this change included 100% of follow-up visits scheduled prior to discharge and a significant reduction in readmissions.	copy is released, the hospital should consider the risk of unauthenticated discharge summaries while also considering the risks of discharging patients without timely discharge information. • PCPs have also requested that they receive inpatient death notices in a timely manner. Consider adopting the same discharge note process for inpatient death. • Consider the addition of a patient oriented discharge summary for the patient that mirrors the information in a discharge summary but in an easy to understand format. In the **TC LHIN,** the Patient Oriented Discharge Summary (PODS) is an example of a discharge summary that was co-designed by patients and freely available to all organizations to adapt and adopt, based on their local context (http://pods-toolkit.uhnopenlab.ca/)

Measurement

Quality Improvement Measures are used to help with monitoring progress in implementation of a change and determining whether that change is leading to improvement. Just as a health care provider may monitor heart rate or blood pressure to determine a patient's response to treatment, collecting information relating to processes for the improved provision of care allows the team to know whether they are consistently moving towards a high reliability care environment. *For more information on **Quality Improvement and Measurement** please visit* http://qualitycompass.hqontario.ca/portal/getting-started.

The following measures have been developed to help to determine: 1) if Innovative Practices for Transitions Between Hospital and Home are being ***implemented***; and 2) the impact of these practices on Health Links ***processes*** and the ***outcomes*** of care at the patient, population, or systems level.

Health Links, organizations, and/or providers that elect to implement one or more of the Innovative Practices for Transitions Between Hospital and Home are **strongly encouraged to collect data on the associated measures and report them to Health Quality Ontario**. This will enhance analysis at the next review (Sept 2017), which will benefit all of the Health Links.

[3]A Primary Care Performance Measurement Framework for Ontario; Report of the Steering Committee for the Ontario Primary Care Performance Measurement Initiative: Phase One [Internet]. Health Quality Ontario; 2014 [cited 2016 July]: http://www.hqontario.ca/portals/0/Documents/pr/pc-performance-measurement-report-en.pdf

Suggested Measurements *(please see Appendix B for additional details)*		
Suggested Outcome Measures	**Suggested Process Measures**	**Additional Information**
1. Percentage of patients with multiple conditions and complex needs who visit the emergency department within seven (7) days post discharge for a similar condition.	2. Percentage of discharge summaries for patients with multiple conditions and complex needs made available to PCPs within 48 hours of discharge.*	• Recommend that Health Links collect and report data for a minimum of three (3) months. • QI RAP templates will be available if the Health Link chooses to use them. • All patients who are receiving care through the Health Link are included in the sample. • Consider stratifying measures from an equity lens.

*This suggested measure is closely aligned to the indicator in Quality Improvement Plans (QIP).

References

1. Baker R. Enhancing the Continuum of Care: Report of the Avoidable Hospitalization Advisory Panel [Internet]. Submitted to the Ontario Ministry of Health and Long-Term Care. 2011 Nov [cited 2016 July]. Available from: http://www.health.gov.on.ca/en/common/ministry/publications/reports/baker_2011/baker_2011.pdf

2. van Walraven C, Seth R, Austin PC, Laupacis A. Effect of Discharge Summary Availability During Post-discharge Visits on Hospital Readmission. J Gen Intern Med. 2002 Mar;17(3):186-192.

Appendix A:
Toronto Central LHIN's Standardized Discharge Summary Template

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Standardized Discharge Summary Template

Version: June 2015

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	The physician who provides primary care for the patient (e.g. family physician). Select 'None' if the patient does not have a primary care provider.
Visit (Encounter)	
Admit date	
Discharge Date	The patient's date of discharge. Defaults to the date the discharge summary is created, but should be updated as the date is revised.
Discharge Diagnosis	The patient's diagnosis following their course in hospital.
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)	The symptom(s) for which the patient initially sought treatment.
Summary of key results	Succinct summary of the patient's clinical course in hospital
Investigations	Examinations and tests conducted while in hospital.
Interventions	Treatment(s) carried out during the course in hospital.
Diagnosis	
Pre-existing/Developed Conditions Impacting Hospital Stay	Conditions that coexist at the time of admission or develop post-admission that require treatment, or increase the length of stay by at least 24 hours or significantly affect the treatment received.
Other Conditions	Pre-existing comorbidities or condition(s) that did not impact the patient's hospital stay.
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	Investigations and interventions recommended to be conducted by the receiving provider after the patient has been discharged.
Referrals	These are referrals that have been initiated by the sender.
Copied to with contact information:	

*Template developed by the Toronto Central LHIN Discharge Planning Task Force

Appendix B: Measurement Specifications for Ensuring a Discharge Summary is Available to Primary Care within 48 Hours

Released September 2016

1. Percentage of patients with multiple conditions and complex needs who visit the emergency department within seven (7) days post discharge for a similar condition

Stage of Hospital Stay	In the community post hospital stay
Innovative Practice	Ensure a discharge summary available to primary care within 48 hours
Type of Measure	Outcome Measure
Definition/Description	Discharge summaries are created by the most responsible physician (MRP) from the inpatient stay and should be available to the PCP within 48 hours of hospital discharge. This is especially important for patients who have multiple conditions and complex needs. Dimensions: Patient-Centered, Safety, Timely Direction of Improvement: ↑
Additional Specifications	Calculation Methods: Numerator/Denominator*100 Numerator: Number of patients who have multiple conditions and complex needs that visit the emergency department within seven (7) days post discharge for a similar condition Denominator: Total number of discharged patients who have multiple conditions and complex needs Exclusion Criteria: Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, have died, transferred to a different facility or signed out
Reporting Period	Recommend that Health Links collect and report data for a minimum of three (3) months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Comments	Selected outcome measures will help to evaluate the impact of the efforts to introduce innovative practices into transitions between hospital and home.

2. Percentage of discharge summaries for patients with multiple conditions and complex needs made available to PCPs within 48 hours of discharge

Stage of Hospital Stay	In the community post hospital stay
Innovative Practice	Ensure a discharge summary available to primary care within 48 hours
Type of Measure	Process Measure
Definition/Description	Discharge summaries are created by the most responsible physician (MRP) from the inpatient stay and should be available to the PCP within 48 hours of hospital discharge. This is especially important for patients who have multiple conditions and complex needs. Dimensions: Patient-Centered, Safety, Timely Direction of Improvement: ↑
Additional Specifications	Calculation Methods: Numerator/Denominator*100 Numerator: Number of discharge summaries sent from hospital to primary care providers within 48 hours for patients who have multiple conditions and complex needs Denominator: Total number of discharged patients who have multiple conditions and complex needs with a discharge summary. Exclusion Criteria: Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, have died, transferred to a different facility or signed out
Reporting Period	Recommend that Health Links collect and report data for a minimum of three (3) months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Comments	The selected process measures are designed to help Health Links draw on the fields of Improvement Science and Implementation Science as these practices are implemented. Process Measures are used to assess: 1. Progress in implementation components such as reach (how often the practice is being used); 2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate; and 3. Sustainability of the process as designed so that it will continue once the initial attention has waned.