Quality Standards Playbook: Transitions Between Hospital and Home

Support for Ontario Health Teams

NOVEMBER 2019

Health Quality Ontario

Let's make our health system healthier

Introduction

The purpose of this document is to describe how the *Transitions Between Hospital and Home* quality standard supports Ontario Health Teams* (OHTs) in providing seamless, fully coordinated care—a key success factor in integrated care delivery systems.

We recommend that users of this guide:

1. Read the *Transitions Between Hospital and Home* quality standard and determine areas your OHT may want to focus its improvement efforts
2. Review and share the *Case for Improvement* deck with your team and stakeholders to understand why this quality standard is needed
3. Take an iterative approach to implementing the quality standard by engaging with your partners in your OHT

*The term “Ontario Health Teams,” or “OHTs,” refers to teams of providers that have placed themselves on the OHT readiness path in Ontario, whether “In Discovery,” “In Development,” “OHT Candidate,” “and Designated OHT.” While this playbook is intended for those teams, any team of providers, regardless of OHT readiness, will find the information in this playbook helpful.

Navigating This Playbook: Focused Views

Audience	Relevant Sections
Executives looking to know how the *Transitions Between Hospital and Home Quality Standard* can support their OHT	• How can this quality standard support my OHT? • How will the quality statements help my OHT meet year 1 expectations? • Are there other quality standards that might support our target populations?
Clinicians/providers looking for information on high-quality transitions between hospital and home, and the tools available to providers in an OHT environment	• How can this quality standard support my OHT? • How the quality statements help us meet year 1 expectations? • What are the 10 quality statements and what do I need to consider in order to implement them? • Are there other quality standards that might support our target populations?
Project managers and project teams looking to create and implement transitions plans in the OHT environment	• How will the quality statements help my OHT meet year 1 expectations? • What are the 10 quality statements and what do I need to consider in order to implement them? • What tools are available to support quality standards implementation?
Patient/caregiver advisors who are members of an OHT planning team or want to participate in the development of a transitions plan for themselves or a loved one	• How can this quality standard support my OHT? • What are the 10 quality statements and what do I need to consider in order to implement them? • What tools are available to support quality standards the implementation?

How can the *Transitions Between Hospital and Home* Quality Standard Benefit my OHT?

At maturity, OHTs will support high-performing integrated care delivery systems across Ontario and seamless transitions for patients between different care settings (e.g., hospital, primary care, long-term care, home and community care) and between different health care providers during an acute or chronic illness.

To help you achieve this, Health Quality Ontario has published a final draft of the *Transitions Between Hospital and Home** quality standard that outlines how your team can achieve a more integrated and coordinated discharge process using the best available evidence. The quality standard includes:

- 10 quality statements that describe how to deliver high-quality care for people as they move between hospital and home
- What outcomes you can hope to achieve by implementing the care outlined in the standard
- What indicators you can use to track the changes you make and measure their success

*This includes people who have been admitted as inpatients to any type of hospital, including complex continuing care facilities and rehabilitation hospitals. “Home” is broadly defined as a person’s usual place of residence and may include personal residences, retirement residences, assisted-living facilities, long-term care facilities, hospices, and shelters. The quality standard covers important aspects of care during the continuum from hospital admission, to preparing for a successful transition, to care provided in the community, in order to ensure seamless transitions.

How Will the Quality Statements Help my Ontario Health Team Meet Year 1 Expectations?

Under the new OHT model, there are two requirements that can be supported by the implementation of the *Transitions Between Hospital and Home* quality standard:

The ***Patient Care and Experience*** year 1 requirement states that access, transitions, coordination, and integration have improved:

- The quality standard was developed after broad consultation with people with lived experience of transitions from hospital to home
- All 10 statements are written from the patient/caregiver perspective, and reflect that the care team, patient, and caregivers must work together from time of admission to ensure there is a seamless transition from the hospital to the community, with coordinated follow-up with appropriate community partners

How will the Quality Statements Help my Ontario Health Team Meet Year 1 Expectations? (cont'd)

The ***Performance Measurement, Quality Improvement, and Continuous Learning*** requirement states that Ontario Health Teams should demonstrate progress to reduce variation and implement clinical standards:

- Each quality statement specifies an area that is critical to the high-quality transition care journey—areas where care needs to be improved and/or where variation exists among regions based on evidence
- Each statement includes indicators teams can use to measure whether their PDSA (Plan-Do-Study-Act) cycle is improving the quality of care for each area of focus
- Incremental improvements in these areas, in the long term, also positively impact the overall measures of success for transitions in care from hospital to home

What are the 10 quality statements and what do I need to consider when implementing them?

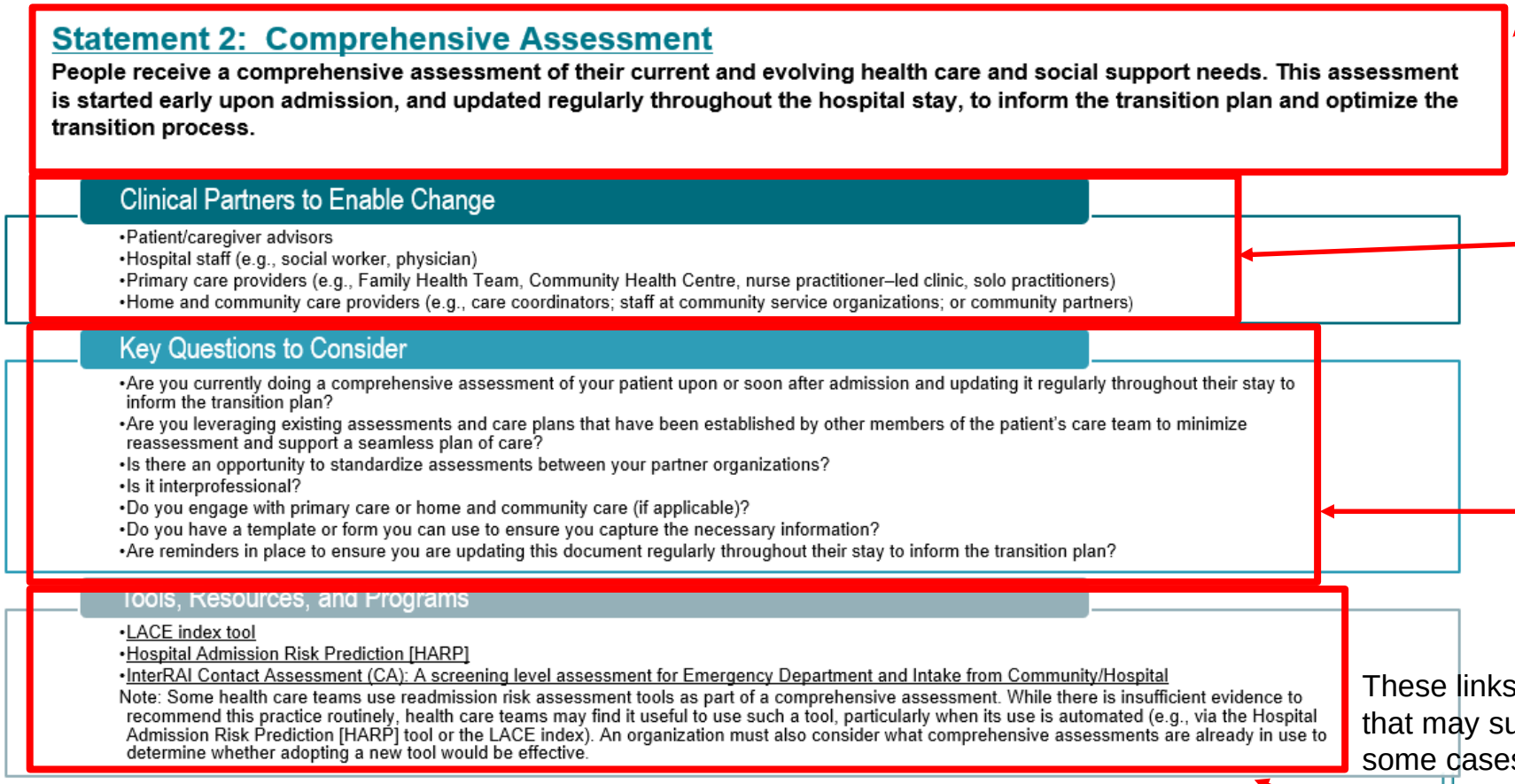
Quality Statements

To go directly to a specific quality statement in the standard, click on the link:

Prioritizing a Statement

- In order to prioritize a statement for action, members of an OHT should determine the current state: review the available data tables to identify variation in care within your region then systematically look at each statement and discuss whether any ongoing work is aligned with its contents.
- All organizations within the OHT should provide perspective on the areas that require improvement and share their experiences implementing similar processes and/or tools.
- While there are many ways to prioritize a statement for action, OHTs might consider implementing one that could help standardize care across organizations; enhance an existing process between organizations; and/or provide an opportunity to build greater patient and caregiver engagement.

Navigating This Section



Statement 2: Comprehensive Assessment

People receive a comprehensive assessment of their current and evolving health care and social support needs. This assessment is started early upon admission, and updated regularly throughout the hospital stay, to inform the transition plan and optimize the transition process.

Clinical Partners to Enable Change

- Patient/caregiver advisors
- Hospital staff (e.g., social worker, physician)
- Primary care providers (e.g., Family Health Team, Community Health Centre, nurse practitioner–led clinic, solo practitioners)
- Home and community care providers (e.g., care coordinators; staff at community service organizations; or community partners)

Key Questions to Consider

- Are you currently doing a comprehensive assessment of your patient upon or soon after admission and updating it regularly throughout their stay to inform the transition plan?
- Are you leveraging existing assessments and care plans that have been established by other members of the patient's care team to minimize reassessment and support a seamless plan of care?
- Is there an opportunity to standardize assessments between your partner organizations?
- Is it interprofessional?
- Do you engage with primary care or home and community care (if applicable)?
- Do you have a template or form you can use to ensure you capture the necessary information?
- Are reminders in place to ensure you are updating this document regularly throughout their stay to inform the transition plan?

Tools, Resources, and Programs

- LACE index tool
- Hospital Admission Risk Prediction [HARP]
- InterRAI Contact Assessment (CA): A screening level assessment for Emergency Department and Intake from Community/Hospital

Note: Some health care teams use readmission risk assessment tools as part of a comprehensive assessment. While there is insufficient evidence to recommend this practice routinely, health care teams may find it useful to use such a tool, particularly when its use is automated (e.g., via the Hospital Admission Risk Prediction [HARP] tool or the LACE index). An organization must also consider what comprehensive assessments are already in use to determine whether adopting a new tool would be effective.

This is the quality statement. Click on the link to see the full background and evidence used to develop this statement.

This is a list of clinical partners you might consider engaging as you work toward implementing this quality statement. This list is not exhaustive, and it might be necessary to engage other clinical partners throughout the planning and implementation of a statement.

This is a list of key questions to consider during the implementation of the statement to assess the effectiveness of the current state, and the gaps between future and current state.

These links take you to tools, resources, and programs that may support you in your implementation efforts. In some cases, there is one tool; in others, multiple tools are listed, and you can select the one that most aligns to your OHT's needs. This is not an exhaustive list of tools or resources. Consider reflecting on whether the tools that are in use across your OHT can assist with the implementation of a statement.

Statement 1: Information Sharing on Admission

When a person is admitted to hospital, the hospital shares information about the admission with their primary care and home and community care providers, as well as any relevant specialist physicians, soon after admission via real-time electronic notification. These providers in the community then share all relevant information with the admitting team in a timely manner.

Clinical Partners to Enable Change

- Patient/caregiver advisors
- Hospital staff (e.g., admitting team member, unit clerks, social worker, physician)
- Primary care providers (e.g., Family Health Team, Community Health Centre, nurse practitioner–led clinic, solo practitioners)
- Home and community care providers (e.g., care coordinators; staff at community service organizations; or community partners)

Key Questions to Consider

- Do you have real-time electronic notification to alert primary care and home and community care providers of the hospital or emergency department admission (and other details, such as diagnoses, predicted discharge date)?
- Do primary care and home and community care teams have a process to provide you information about your admitted patient?
- Are you able to get information from community providers?
- Is it working well? If not, what can be improved?
- What are the barriers to making improvements?
- How user-friendly is the process?

Tools, Resources, and Programs

- eNotifications
- Ocean eReferral Network
- Ontario eConsult Program
- Client Health and Related Information System (CHRIS)
- Shared Health Integrated Information Portal (SHIIP)

Statement 2: Comprehensive Assessment

People receive a comprehensive assessment of their current and evolving health care and social support needs. This assessment is started early upon admission, and updated regularly throughout the hospital stay, to inform the transition plan and optimize the transition process.

Clinical Partners to Enable Change

- Patient/caregiver advisors
- Hospital staff (e.g., social worker, physician)
- Primary care providers (e.g., Family Health Team, Community Health Centre, nurse practitioner–led clinic, solo practitioners)
- Home and community care providers (e.g., care coordinators; staff at community service organizations; or community partners)

Key Questions to Consider

- Are you currently doing a comprehensive assessment of your patient upon or soon after admission and updating it regularly throughout their stay to inform the transition plan?
- Are you leveraging existing assessments and care plans that have been established by other members of the patient's care team to minimize reassessment and support a seamless plan of care?
- Is there an opportunity to standardize assessments between your partner organizations?
- Is it interprofessional?
- Do you engage with primary care or home and community care (if applicable)?
- Do you have a template or form you can use to ensure you capture the necessary information?
- Are reminders in place to ensure you are updating this document regularly throughout their stay to inform the transition plan?

Tools, Resources, and Programs

- LACE index tool
- Hospital Admission Risk Prediction [HARP]
- InterRAI Contact Assessment (CA): A screening level assessment for Emergency Department and Intake from Community/Hospital

Note: Some health care teams use readmission risk assessment tools as part of a comprehensive assessment. While there is insufficient evidence to recommend this practice routinely, health care teams may find it useful to use such a tool, particularly when its use is automated (e.g., via the Hospital Admission Risk Prediction [HARP] tool or the LACE index). An organization must also consider what comprehensive assessments are already in use to determine whether adopting a new tool would be effective.

Statement 3: Patient, Family, and Caregiver Involvement in Transition Planning

People transitioning from hospital to home are involved in transition planning and developing a written transition plan. If people consent to include them in their circle of care, family members and caregivers are also involved.

Clinical Partners to Enable Change

- Patient/caregiver advisors
- Hospital staff (e.g., social worker, physician)
- Home and community care providers (e.g., care coordinators; staff at community service organizations; or community partners)
- System navigators (e.g., transitional care facilitator)
- Member of the patient's primary care team

Key Questions to Consider

- Are patients currently discharged from hospital with a transition plan? Is it written down?
- Are their primary caregivers involved in the development of the transition plan?
- Does the transition plan include information on what situations warrant a return to hospital?
- Do we have a consistent approach to including patients and their caregivers in developing transition plans?
- Are we considering the patients' needs and preferences in the development of the care plan?
- Do patients know who to call if they have questions or concerns?
- Does the patient know who and when they will have contact with a member of their primary care team

Tools, Resources, and Programs

- Continuity of Care: Transitions in Care
- Guides and Checklists for Family Caregivers
- Coordinated Care Plan (CCP)
- Coordinated Care Plan User Guide

Statement 4: Patient, Family, and Caregiver Education, Training and Support

People transitioning from hospital to home, and their families and caregivers, have the information and support they need to manage their health care needs after the hospital stay. Before transitioning from hospital to home, they are offered education and training to manage their health care needs at home, including guidance on community-based resources, medications, and medical equipment.

Clinical Partners to Enable Change

- Patient/caregiver advisors
- Hospital staff (e.g., social worker, physician)
- Primary care providers (e.g., Family Health Teams, Community Health Centres, nurse practitioner–led clinics, solo practitioners)
- Home and community care providers (e.g., care coordinators; staff at community service organizations; community partners)
- System navigators (e.g., transitional care facilitator)

Key Questions to Consider

- Do you offer education, training, and support to patients/families/caregivers to manage their health care needs after their hospital stay?
- Do you tailor the information and training to the patient's needs, perception of their health condition, their cognitive ability, and their stage of readiness to care for themselves, and the family's or caregiver's willingness and capacity to care for the patient?
- Is this information or instruction provided in a variety of formats (e.g., verbal, written, or electronic) using plain language and visual tools?
- If needed, do you provide hands-on training (e.g., to use medical equipment, administer medication, change bandages)?
- Are the community-based resources named in this education available in your community?
- Is the information and training culturally appropriate and accessible for all involved (e.g., accommodating physical, sensory, or learning disabilities or provided in the patient's first language)?
- Do you ensure that a member of the hospital team is made responsible for providing the patient, family, and caregivers with information and support to allow for a successful transition home?

Tools, Resources, and Programs

- Patient Oriented Discharge Summary (PODS)

Statement 5: Transition Plans

People transitioning from hospital to home are given a written transition plan, developed by and agreed upon in partnership with the patient, any involved caregivers, the hospital team, and primary care and home and community care providers before leaving hospital. Transition plans are shared with the person's primary care and home and community care providers and any relevant specialist providers within 48 hours of discharge.

Clinical Partners to Enable Change

- Patient/caregiver advisors
- Hospital staff (e.g. member of discharge team, unit clerk)
- Primary care providers (e.g., Family Health Teams, Community Health Centres, nurse practitioner–led clinics, solo practitioners)
- Home and community care providers (e.g., care coordinators; staff at community service organizations; community partners)
- System navigators (e.g., transitional care facilitator)

Key Questions to Consider

- Do you involve the patient (and family or caregivers who will be supporting the patient when they leave the hospital) in developing the transition plan?
- Is the interprofessional team involved in developing the transition plan (including hospital, primary care, and home and community care providers if applicable)?
- Do you have a process in place to give a written copy of the transition plan (e.g., PODS) to the patient/caregivers before they leave hospital?
- Do you have a way to ensure that information (i.e., transition plan) is transferred to the home and community care providers and primary care team within 48 hours?
- Do you have access to professional interpreters?
- Are you able to recognize and address patients' cultural needs?

Tools, Resources, and Programs

- Patient Oriented Discharge Summary (PODS)
- Coordinated Care Plan (CCP)
- Coordinated Care Plan User Guide

Statement 6: Coordinated Transitions

People admitted to hospital have a named health care professional who is responsible for timely transition planning, coordination, and communication. Before people leave hospital, this person ensures an effective transfer of transition plans and information related to people's care.

Clinical Partners to Enable Change

- Patient/caregiver advisors
- Hospital staff (e.g., members of the discharge team)
- Primary care providers (e.g., Family Health Teams, Community Health Centres, nurse practitioner–led clinics, solo practitioners)
- Home and community care providers (e.g., care coordinators; staff at community service organizations; community partners)
- System navigator (e.g., transitional care facilitator)

Key Questions to Consider

- Do you have a named person (health care professional) responsible for transition planning, coordination, and communication to ensure an effective transfer of transition plans and information?
- Does the patient know who is responsible for transition planning (what service they are providing/function they serve)?

Tools, Resources, and Programs

- CoHealth App
- Coordinated Care Plan (CCP)
- Coordinated Care Plan User Guide

Statement 7: Medication Review and Support

People transitioning between hospital and home have medication reviews on admission, before returning home, and once they are home. These reviews include information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and options are provided for those unable to afford these costs.

Clinical Partners to Enable Change

- Patient/caregiver advisors
- Hospital staff (e.g., member of discharge team, pharmacist)
- Home and community care (e.g., care coordinator, community pharmacist, community social worker; community nurse practitioner)
- Primary care providers (e.g., Family Health Teams, Community Health Centres, nurse practitioner–led clinics, solo practitioners)

Key Questions to Consider

- Is there a process to complete medication reviews on admission, before discharge, and when they return home?
- Is there a process to review medications (on admission, before discharge, and on return home) with the patient/caregiver?
- What processes/ resources do you have in place to support patients that cannot afford necessary medications?

Tools, Resources, and Programs

- Best Possible Medication Discharge Plan
- Hospital to Home – Facilitating Medication Safety at Transitions
- Medication Reconciliation in Acute Care
- Medications at Transitions and Clinical Handoffs (MATCH)
- Ontario Primary Care Medication Reconciliation Guide
- MyMedRec
- 5 Questions to Ask About Your Medications

Statement 8: Coordinated Follow-Up Medical Care

People transitioning from hospital to home have follow-up medical care with their primary care provider and/or a medical specialist coordinated and booked before leaving hospital. People with no primary care provider are provided with assistance to find one.

Clinical Partners to Enable Change

- Patient/caregiver advisors
- Hospital staff (e.g., member of the discharge team, unit clerk)
- Primary care providers (e.g., Family Health Teams, Community Health Centres, nurse practitioner–led clinics, solo practitioners)
- Home and community care providers (e.g., care coordinators; staff at community service organizations; community partners)
- System navigator (e.g., transitional care facilitator)

Key Questions to Consider

- Is follow-up medical care coordinated and booked before leaving hospital?
- If the patient/caregiver is responsible for booking the follow-up appointment, is there a process to make sure they are given clear instructions about the appointment and who they need to call?
- If people do not have a primary care provider, is there a process to help them find one (e.g., Health Care Connect)?
- What if people face challenges getting to follow-up appointments (e.g., due to their health condition, lack of transportation, cost, geographical barriers)—is there a process to help them?
- What about people at high risk for readmission—is there process to arrange a follow-up phone call, home visit, or office visit (within 24-72 hours)?
- Are people attached to a primary care provider before discharge (if they don't already have one)? If so, who is responsible for this?

Tools, Resources, and Programs

- Health Care Connect

Statement 9: Appropriate and Timely Support for Home and Community Care

People transitioning from hospital to home are assessed for the type, amount, and appropriate timing of home care and community support services they and their caregivers need. When these services are needed, they are arranged before people leave hospital and are in place when they return home.

Clinical Partners to Enable Change

- Patient/caregiver advisors
- Home and community care providers (e.g., care coordinators; staff at community service organizations; community partners)
- System navigator (e.g., transitional care facilitators)

Key Questions to Consider

- Is there a process to work with patients and caregivers, their hospital teams, and home and community care providers to understand each patient's goals and preferences, to regularly assess their home care and community support service needs (type, amount, appropriate timing), and to develop (or co-design) a care plan to meet their needs and achieve their goals?
- Who should lead this coordination of services?
- How is limited availability in the community addressed?
- What processes can help you efficiently manage this process?
- What needs will caregivers require beyond the patients' needs?

Tools, Resources, and Programs

- Home at Last
- Home First Philosophy
- Integrated Comprehensive Care (ICC)
- Priority Assistance to Transition Home (PATH)
- InterRAI Contact Assessment (CA): A screening level assessment for Emergency Department and Intake from Community/Hospital

Statement 10: Out-of-Pocket Costs and Limits on Funded Services

People transitioning from hospital to home have their ability to pay for any out-of-pocket health care costs considered by the health care team, and information and alternatives for unaffordable costs are included in transition plans. The health care team explains to people what publicly funded services are available to them and what services they will need to pay for.

Clinical Partners to Enable Change

- Patient/caregiver advisors
- Hospital staff (e.g., member of discharge team, unit clerk)
- Primary care providers (e.g., Family Health Teams, Community Health Centres, nurse practitioner–led clinics, solo practitioners)
- Home and community care providers (e.g., care coordinators; staff at community service organizations; community partners)
- System navigators (e.g., transitional care facilitator)

Key Questions to Consider

- Is there a process to assess what services/equipment/medications are funded and what are not?
- Whose role is this?
- How can I provide information on each so that individual patient needs are met?
- At what point in the patient's care journey do I solicit the information I need to meet the care outlined in this statement?
- Are there social issues (e.g. lack of transportation, housing) impacting the patient's ability to pay?
- What system-level barriers exist that may hinder the care I deliver and how can I circumvent them for the time being?

Tools, Resources, and Programs

- Centre for Effective Practice Poverty Assessment Tool
- ODSP application

What tools does Health Quality Ontario have to support the implementation of the *Transitions Between Hospital and Home* quality standard?

Resource	Summary	Audience
Getting Started Guide	A guide to quality improvement for health care professionals that includes tools and resources, such as an action plan template. It can be used by OHTs as a first step to designing quality improvement projects related to the quality standard.	Project managers, project teams, and clinicians/providers
Patient Guide	A tool to help patients to know what to ask for during transitions in care. It can be used by OHTs to support patient and provider conversations.	Patient/caregiver advisors, clinicians/providers, project managers, and project teams
Data Table	A downloadable Excel file containing data on the quality standards' measures of success at the regional and hospital levels. It can be used by OHTs to identify gaps in care in your region, inform resource planning, and develop improvement efforts.	OHT leadership, clinicians/providers, project managers, project teams, and decision support specialists

Resource	Summary	Audience
Measurement Guide	A supporting document to the data table that contains measurement principles, data collection methods, and the and the technical specifications for the measures of success for the quality standard that are provincially and locally measurable. It can be used by OHTs as a resource to guide the development of the same indicators at the local level.	Decision support specialists, quality improvement team/project teams
Case for Improvement slide deck	A presentation about why this standard was needed, and the data behind it. OHTs can share the document with partners to secure support and buy-in to put the quality standard into practice.	OHT leadership, clinicians/providers, patient/caregiver advisors, project managers, and project teams
Transitions From Hospital to Home: Patient and Caregiver Priorities	A summary of the findings from the patient consultations that supported the development of the statements. It can be used by OHTs as a reference to demonstrate challenges with transitions as identified by patients and caregivers.	Patient/caregiver advisors, project managers, project teams, and clinicians/providers

Resource	Summary	Audience
Recommendations for Adoption (forthcoming)	System-wide recommendations that address barriers to implementing the care outlined in the quality standard. If acted upon, these will help health care professionals and organizations implement the statements. OHTs can implement recommendations directed to them as applicable and where appropriate.	OHT leadership
Quorum	Quorum is an online community dedicated to improving the quality of health care in Ontario. The information on the QI Tools and Resources page and its additional tabs describe quality improvement (QI) methodology, which takes a step-step, iterative approach to QI initiatives. Examples of organizations implementing initiatives to address transitions in care can be found on Quorum by clicking the effective transitions tag.	Project managers, project teams, and clinicians/providers

Are there other quality standards that might support our target populations?

Year 1 Patient Populations					
Quality Standard*	**High-Risk or Medically Complex Seniors**	**People Affected by Mental Health Conditions and/or Addictions**	**People Living With Pain**	**People Living With a Life-Limiting Disease**	**People Living With a Chronic Disease**
Behavioural Symptoms of Dementia	X	X			X
Chronic Obstructive Pulmonary Disease	X			X	X
Chronic Pain Care		X	X	X	X
Dementia Care in Community	X	X		X	X
Diabetes – Prediabetes and Type 2 Diabetes (forthcoming)	X	X		X	X

*Health Quality Ontario has published several quality standards to date and more are on the way. Recognizing that many OHTs are focused on identifying ways to improve integrated care for the people in their regions who most require it, Health Quality Ontario has aligned many of our existing quality standards to common patient populations. All other quality standards can be found at hqontario.ca/qualitystandards.

Year 1 Patient Populations					
Quality Standard	**High-Risk or Medically Complex Seniors**	**People Affected by Mental Health Conditions and/or Addictions**	**People Living With Pain**	**People Living With a Life-Limiting Disease**	**People Living With a Chronic Disease**
Diabetic Foot Ulcer – Wound Care			X	X	X
Glaucoma	X				
Heart Failure Care in the Community	X			X	X
Hip Fracture	X			X	X
Low Back Pain			X		
Major Depression		X			X
Opioid Prescribing for Chronic Pain			X		X
Opioid Prescribing for Acute Pain			X		

Year 1 Patient Populations					
Quality Standard	**High-Risk or Medically Complex Seniors**	**People Affected by Mental Health Conditions and/or Addictions**	**People Living With Pain**	**People Living With a Life-Limiting Disease**	**People Living With a Chronic Disease**
Opioid Use Disorder		X			
Osteoarthritis	X				X
Palliative Care			X	X	X
Pressure Injuries – Wound Care			X		
Schizophrenia Care in the Community		X			X
Schizophrenia Care in Hospital		X			X
Venus Leg Ulcers – Wound Care			X		X

If you have any questions or feedback about this guide please contact us using the information below.

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