Quality Standards Playbook: Transitions Between Hospital and Home

Support for Ontario Health Teams

NOVEMBER 2019

Health Q

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

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m of providers, regardless of

OHT readiness, will find the information in this playbook helpful.

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 d-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

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

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:

1. Information-Sharing on Admission
2. Comprehensive Assessment
3. Patient, Family, and Caregiver Involvement in Transition Planning
4. Patient, Family, and Caregiver Education, Training, and Support
5. Transition Plans
6. Coordinated Transitions
7. Medication Review and Support
8. Coordinated Follow-Up Medical Care
9. Appropriate and Timely Support for Home and Community Care
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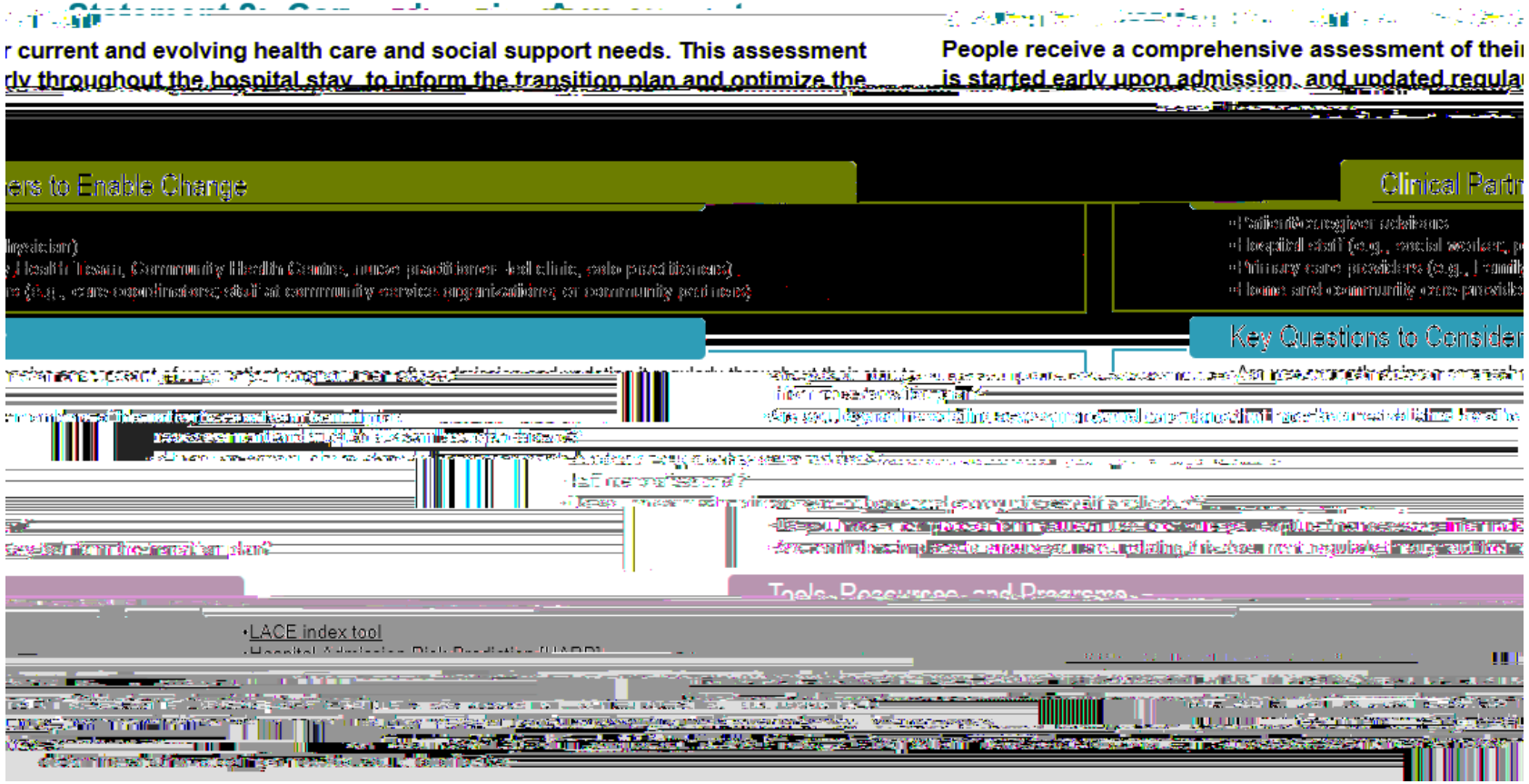
current and evolving health care and social support needs. This assessment
rly throughout the hospital stay, to inform the transition plan and optimize the
People receive a comprehensive assessment of thei
is started early upon admission, and updated regula
ers to Enable Change
Clinical Partn
Key Questions to Consider
•LACE index tool

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.

Patient/caregiver advisors
Hospital staff (e.g., admitting team member, unit clerks, social worker, physician)

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

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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)

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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

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-

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 understa
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?

Home at Last
Home First Philosophy
Integrated Comprehensive Care (ICC)
Priority Assistance to Transition Home (PATH)

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)

Is there a process to assess what services/equipment/medications are funded and what are not?
Whose role is this?
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Resource	Summary	Audience
Measurement Guide	A supporting document to the data table that contains measurement principles, data collection methods, and the	

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	

Are there other stakeholders that might

Year 1 Patient Populations					
Quality Standard	**High-Risk or Medically**				

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

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