RESOURCE GUIDE

High-Quality Care Transitions: A Guide to Improving Continuity of Care (Online Guide)

September 2018

SASKATCHEWAN HEALTH QUALITY COUNCIL

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About Us

HQC is an independent provincial organization focused on accelerating improvement in the quality of health care in Saskatchewan. Established by government legislation in 2002, we work with patients and families, clinicians, administrators, researchers, and quality improvement specialists to make health care better and safer for everyone in Saskatchewan.

HQC accelerates improvement of health and health by building improvement capability and spreading innovation throughout the province, through education, improvement initiatives, and research.

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How to use this guide

This guide is for people who want to improve care transitions for the people they serve, but are not sure of the evidence, where to start, or need some inspirations for improvements.

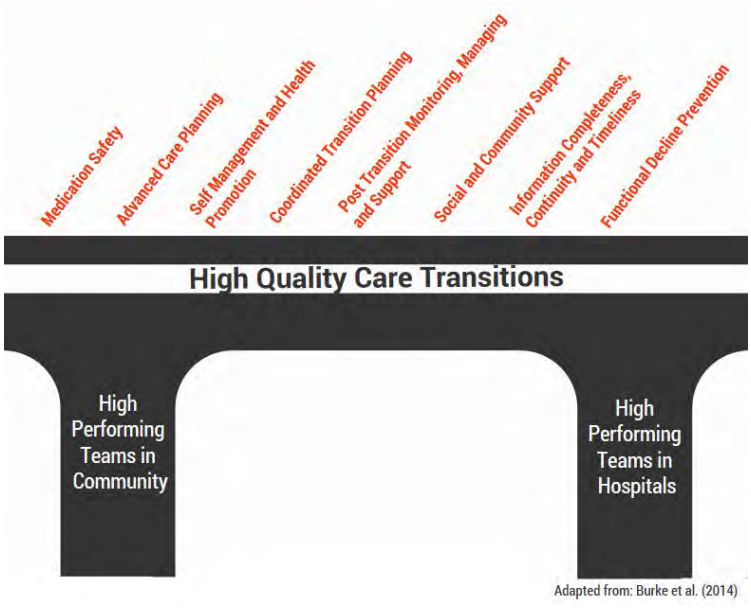
In each section of this resource guide, you'll find information grouped into a number of categories:

- *Background:* a summary as to why this domain is important and a list of the leading operational practices that indicate a focus on that particular domain
- *Evidence:* published research or reliable data illustrating the impact of improvement in this domain
- *Improvement Inspiration and Resources:* examples of work that has been done in other health systems
- *Data Available in Saskatchewan:* examples of metrics currently tracked or otherwise available within our provincial health system. You can use these to track how your changes are making an impact.

There are eight domains included in the *High-Quality Care Transitions* bridge, which is built on high-performing teams in community and in hospital (Figure 1):

- Medication Safety
- Advanced Care Planning (Shared Care Planning and Decision Making)
- Self-Management and Health Promotion
- Coordinated Transition Planning
- Timely Follow-up for Post-Transition Monitoring, Managing and Support
- Social and Community Support
- Information Flow (Completeness, Continuity and Timeliness)
- Functional Decline Prevention

Figure 1: Pillars of good transitional care



Source: Original, Emergency Department Waits and Patient Flow Initiative

Introduction:
High-Quality Care Transitions

Background

In 2016, staff involved with the *Emergency Department Waits and Patient Flow Initiative* did an extensive literature review to identify interventions that could improve emergency department wait times in Saskatchewan. The team then used computer modelling to determine how these different interventions might impact our wait times.

The intervention shown to have the great impact was *individualized discharge planning*. The article it comes from ("Individualized Discharge Planning from Hospital to Home"*)* was based on a Cochrane Review by Shepperd et al. that included 24 randomized controlled trials, with a total of 8,098 patients.

Patients with a medical diagnosis who received individualized discharge planning had lengths of stay almost a day shorter than patients without the intervention (-0.91 days) and a 12 percent reduction in their three-month readmission risk. If we could achieve these same results in Saskatchewan, we would meet the provincial targets set for emergency department wait times.

There are many different models, frameworks, strategies, and programs aimed at reducing inappropriate length of stay and readmission rates through improved discharge planning or care transitions. To guide improvement work in Saskatchewan, the patient flow team adopted a framework called the *Ideal Transition in Care* Bridge created by Burke et al.

The framework recommends a number of domains that can be addressed to achieve seamless care transitions. Foundational to this work is having patient/families, hospital teams, and community teams working in partnership to improve care processes in these domains to achieve our shared goals in reducing wait times, readmission rates and improve the overall care experience for patients in Saskatchewan.

Evidence

- Identifying keys to success in reducing readmissions using the ideal transitions in care framework (Burke, et al. 2014) - *BMC Health Services Research 2014 14:423*
- Moving beyond readmission penalties: creating an ideal process to improve transitional care (Burke et al., 2013) - *J. Hosp. Med. 2013 February;8(2):102-109*
- Reducing Hospital Readmission: Current Strategies and Future Directions (Kripalani et al, 2014) - *Annual Review of Medicine Vol. 65:471-485*
- Transitional Care Strategies from Hospital to Home (Rennke & Ranji, 2015) - *Neurohospitalist. 2015 Jan; 5(1): 35–42*
- Components of Comprehensive and Effective Transitional Care (Naylor et al., 2017) - *J Am Geriatr Soc. 2017 Jun;65(6):1119-1125*
- Caregiver Integration During Discharge Planning for Older Adults to Reduce Resource Use: A MetaAnalysis (Rodakowski et al., 2017) - *J Am Geriatric Soc. 2017 Aug;65(8):1748-1755*

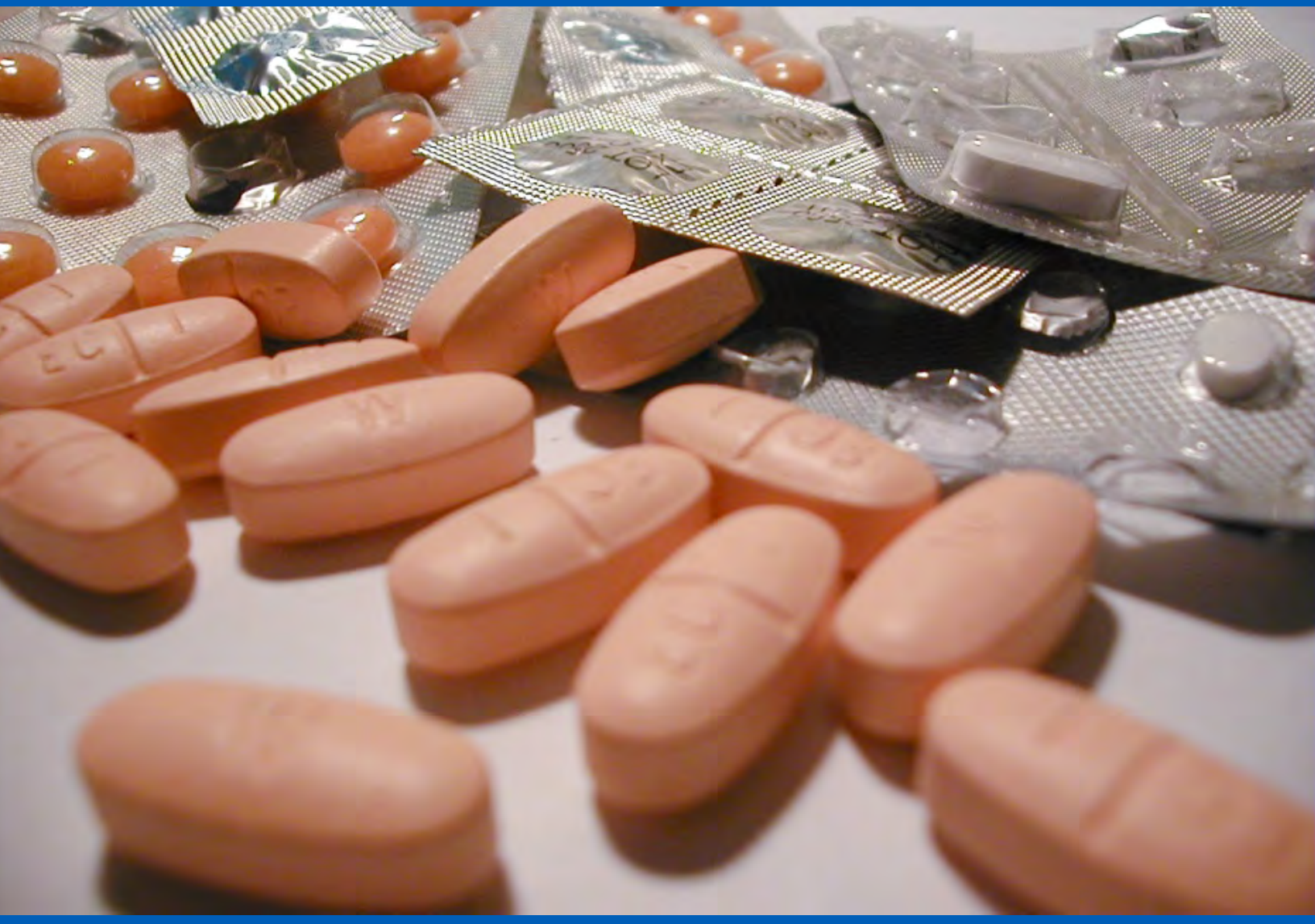
Multi-Domain Transition Programs

- IDEAL Discharge Planning - *Agency for Healthcare Research and Quality*
- Care Transitions Program©
- Better Outcomes by Optimizing Safe Transitions (BOOST) - *Society of Hospital Medicine*
- Project Re-engineered Discharge (Project ReD) - *A Research Group at Boston University Medical Center*
- The Transitional Care Model - *Hirschman, K., Shaid, E., McCauley, K., Pauly, M., Naylor, M., (September 30, 2015) "Continuity of Care: The Transitional Care Model" OJIN: The Online Journal of Issues in Nursing Vol. 20, No. 3, Manuscript 1.*
- Tools: Interventions to Reduce Acute Care Transfers (INTERACT ®) - QI Initiative for Nursing Homes

Additional Resources

- Transitional Care Services : A Nurse Led Quality Improvement Project - *Conroy-McCue, Debra, Doctor of Nursing Practice(DNP) Projects. 47*
- Adopting a Common Approach to Transitional Care Planning - *Health Quality Ontario*
- Seamless Transitions: Hospital to Home Transitions Guidebook - *Trillium Health Partners and Mississauga Halton CCAC partnership initiative*
- 2017 Readmissions Change Package - *Health Research & Educational Trust (February 2017). Preventable Readmissions Change Package: 2017 Update. Chicago, IL: Health Research & Educational Trust.*
- Care Transitions: *Registered Nurses Association of Ontario* Clinical Best Practice Guidelines
- Care Transitions: Evidence Informed Improvement Package - *Health Quality Ontario*
- Hot Topics in Healthcare: Transitions of Care: The need for a more effective approach to continuing patient care - *The Joint Commission*

Domain 1: Medication Safety



Background

Patients are at a very high risk related to medication errors during care transitions. Medication errors continue to be a significant source of avoidable harm to patients who enter, transition through and leave our healthcare system. In Canada, published acute care studies have demonstrated that 40 - 50% of patients at admission and 40% at discharge experience unintentional medication discrepancies or potential errors. (*Source: Optimizing Medication Safety at Care Transitions- Creating a National Challenge)*

Leading Operational Practices:

- Clients who require medication reconciliation are identified and documented.
- At the beginning of services, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, health care providers, caregivers, and other as appropriate.
- Medication discrepancies are resolved in partnership with clients and families or communicated to the client's most responsible prescriber. Actions taken to resolve medication discrepancies are documented.
- When medication discrepancies are resolved, the current medication list is updated and provided to the client or family along with clear information about the changes that were made.
- Upon or prior to readmission from another service environment, the discharge medication orders are compared with the current medication list and any medication discrepancies are identified, resolved and documented.

Evidence

- Effectiveness of pharmacist-led medication reconciliation programmes on clinical outcomes at hospital transitions: a systematic review and meta-analysis - *Mekonnen, McLachlan, and Brien, BMJ Open. 2016; 6(2): e010003*
- Effect of an In-Hospital Multifaceted Clinical Pharmacist Intervention on the Risk of Readmission: A Randomized Clinical Trial - *Ravn-Nielsen, et al, JAMA Intern Med. 2018 Mar 1;178(3):375-382*

Improvement Inspiration and Resources

- Article: New Thinking on Medication Reconciliation - *Institute for Healthcare Improvement*
- Toolkit: Medication Reconciliation: Getting Started Kit - *Canadian Patient Safety Institute*
- Tools and Resources: Measures: Medication Reconciliation - *Canadian Patient Safety Institute*
- Article: An Intervention to Prevent Med Rec errors: The Discharge Time Out - *Lorincz I, Patel N, Savitz J, Aya V, Myers J. An Intervention to Prevent Medication Reconciliation Errors: The Discharge Timeout [abstract].* Journal of Hospital Medicine. *2011; 6 (suppl 2).*
- Article: BOOMR: Better Coordinated Cross-Sectoral Medication Reconciliation for Residential Care - *Vuong et al. Healthcare Quarterly, Vol.20 No.1 2017*
- Video and Article: Optimizing Care Transitions: The Role of the Community Pharmacist - *Melody, McCartney, Sen, & Duenas, Integrated Pharmacy Research and Practice, 2016:5 43–51*
- Slide Share: Your Discharge is Someone Else's Admission - *Canadian Patient Safety Institute*
- Patient Education Video: One Simple Solution for Medication Safety – *Dr. Mike Evans*
- Patient Online Tool: My Medication Record (personalized, printable medication record) - *Institute for Safe Medication Practices Canada*

Data Available in Saskatchewan

- % of patients with medication reconciliation complete, Adverse Drug Events

Domain 2:
Advanced Care Planning
(Shared Care Planning and Decision Making)

Background

Establishing patient/ family centered goals of care is an essential part of ensuring high quality care. Often, people do not want to be in hospital at the end of their life, but have not had the opportunity to make that goal clear to their care team. There has been extensive research and reporting on the value of advanced care planning in the health care system, not only for people receiving palliative care. Research has shown that advanced care planning and end-of-life conversations between care providers and patients/families reduce the use of unwanted life-sustaining procedures and hospitalizations, lower rates of ICU admissions, and improve care satisfaction/quality of life ratings by patients and families at end-of-life.

Leading Operational Practices:

- The client, their family and caregivers and the inter-professional team collaborate to develop a care plan that supports the unique needs of the client while promoting safety and continuity of care.
- Advanced Care Plans completed on patients/clients being cared for and are readily accessible by care teams as needed.

Evidence

- Failure to Engage Hospitalized Elderly Patients and Their Families in Advance Care Planning (Heyland et al., 2013) - *JAMA Intern Med. 2013;173(9):778-787.*
- Health Care Use at the End of Life in Western Canada (2007) - *Canadian Institute for Health Information*
- Advance Care Planning in Canada: National Framework - *Canadian Hospice Palliative Care Association*
- Advanced Care Planning in Canada: 5 Year Plan - *National Advance Care Planning Task Group*
- Fact Sheet: Hospice Palliative Care in Canada - *Canadian Hospice Palliative Care Association*

Improvement Inspiration and Resources

- Speak Up Campaign (Resource Library) - *National Advance Care Planning Task Group*
- My Voice - *Advance Care Planning Guide, Saskatchewan Health Authority*
- Video: Advanced Care Planning - *Saskatchewan Health Authority*
- Video: Advanced Care Planning: Talking to Your Community - *National Advance Care Planning Task Group*
- Advanced Care Planning Kit – 2016 Saskatchewan Edition - *End of Life Planning Canada*

Data Available in Saskatchewan

- Days in hospital last 6 months of life

Domain 3:
Self-Management and Health Promotion

Background

According to *the Agency for Healthcare Quality and Research*, studies have shown that patients immediately forget 40-80 per cent of the medical information they're told, and nearly half of the information they do retain is incorrect. This poses a serious challenge to achieving high quality care transitions because, in the absence of electronic communication systems, patients and families are often responsible for relaying information between providers.

Leading Operational Practices:

- Discharge counseling is focused on major diagnoses, medication changes, dates of follow-up appointments, self-care instructions, warning signs and symptoms, and who to contact for problems.
- Simply written, patient-centered instructions and information are provided to patients/families on discharge.
- Teach-back methods are used to confirm understanding.
- Transition coaches are used for high-risk patients.
- Patient/Caregiver teaching continues post-discharge follow-up.

Evidence

- For teach-back and other health literacy interventions: Evidence Summary – *Teach-back! Training*

Improvement Inspiration and Resources

Health Literacy

- Video: Health Literacy Basics for Health Professionals – *Vancouver Coastal Health Primary Care*
- Health Literacy Universal Precautions Toolkit – *Agency for Healthcare Quality and Research*
    - Video: Health Literacy Universal Precautions Toolkit

Teach-back

- Teach-back! Training
    - Always Use Teach-back!
    - Video: Using the Teach-back Tool
    - Video: Teach-back Observation Tool
- Video: Teach-Back in Action - *North Western Melbourne Primary Health Network*
- Video: What is Teach-Back? – *Institute for Healthcare Improvement*
- Video: Teachback Training Video – *Central Maine Medical Center*

Transition Coach / Discharge Advocate

- In the Incubator: Transition Coaches – *Center for Care Innovations*
- ACO Care Transitions: Coaching, Management, and Coordination – *Patient Safety and Quality Healthcare*

- News Release: Care Transition Program Significantly Lowers Hospital Readmission Rates, According to Data from the Bronx Collaborative
- Discharge Advocate Training Manual - *Project ReD*

Patient Activation

- Video: What is Patient Activation? – *Altarum Institute*
- Video: Patient Activation Measure and Care Transitions – *Healthy Transitions Colorado*
- Readmission Change Package (2017): Use Teachback to validate patient understanding (page 11) – *Health Research and Educational Trust*

Patient / Family Resources

- "Ask Me 3" Campaign / "Ask Me 3" Video – *Institute for Healthcare Improvement*
- Health Literacy Patient Survey – *Agency for Health Care Quality and Research*

Data Available in Saskatchewan

Readmissions Rates, Emergency Revisit Rates

Domain 4:
Coordinated Transition Planning

Background

The time around discharge from hospital can be a challenge. It's a sensitive time with potential for miscommunication despite the fact that patients and care providers all want it to go smoothly and error-free. Having strong processes between hospital and community-based teams is critical to ensuring a seamless care transition. Coordinated transition planning refers to attentive management of the care transition process across care teams, with particular focus on care transitions into and out of the hospital.

Leading Operational Practices:

- The Estimated/Targeted Date of Transition is discussed daily at rounds.
- An interdisciplinary care team creates a transition plan in partnership with patient/families.
- The client's current and evolving care requirements are assessed on admission, regularly throughout an episode of care, in response to a change in health status or care needs, at shift change, and prior to transition.
- The client is assessed for physical and psychological readiness for a care transition.
- The client, their family and caregivers are assessed for factors known to affect the ability to learn self-care strategies before, during and after a transition.
- The learning and information needs of the client, their family and caregivers to self-manage care before are assessed during and after a transition.
- Effective communication strategies are used to share client information among members of the interprofessional team during care transition planning.
- Clients, families and caregivers are educated about the care transition during routine care, tailoring the information to their needs and stage of care.
- The effectiveness of transition planning on the client, their family and caregivers are evaluated before, during and after a transition.
- "Warm" (verbal) accountability handovers are conducted when patient care is transitioned from one care provider/team to another.

Evidence

- Article: Discharge Planning from Hospital - *Gonçalves-Bradley DC, Lannin NA, Clemson LM, Cameron ID, Shepperd S. Cochrane Database of Systematic Reviews 2016, Issue 1. Art. No.: CD000313*
- Slides: RED, BOOST and You: Improving the Discharge Transition of Care - *Massachusetts General Hospital*
- Best Practice Guide**:** Care Transitions - *Registered Nurses' Association of Ontario*

Improvement Inspiration and Resources

- NHS Guide to Reducing Long Hospital Stays - *NHS Improvement*
- Improving Transitions from the Hospital to Post-Acute Care Settings to Reduce Avoidable Rehospitalizations - *Institute for Healthcare Improvement*
- Comprehensive Discharge Planning - *Reducing Avoidable Readmissions Effectively*
- Discharge Planning Guidelines for Inpatient Rehabilitation - *GTA Rehab Network*

- Article: Development of a checklist of safe discharge practices for hospital patients - *Soong C, Daub S, Lee J, Majewski C, Musing E, Nord P, Wyman R, Baker GR, Zacharopoulos N, Bell CM, J. Hosp. Med 2013;8;444-449*
- Presentation: Post Acute Care Enablement (PACE) & Triage Rapid Elderly Assessment Team (TREAT) - *Royal Free London NHS Foundation Trust*
- Adopting a Common Approach to Transitional Care Planning: Helping Health Links Improve Transitions and Coordination of Care - *Health Quality Ontario*
- IDEAL Discharge Planning Overview, Process, and Checklist - *Agency for Healthcare Research and Quality*

Data Available in Saskatchewan

% of patients with discharge date discussed at IDR/SIBR™, Readmission Rates, ED Revisit Rates, Unnecessary Hospital Days/ALC

Domain 5:

Timely Follow-Up for Post Transition Monitoring, Management, and Support

Background

The risk of readmission to hospital can be lowered by early identification of worsening symptoms, medication side effects, or self-management challenges. A variety of interventions should be used to ensure patients receive proper monitoring, management and support following a care transition to respond to concerns in a timely way.

Leading Operational Practices:

- Patients with a moderate-to-high readmission risk are seen by their Most Responsible Provider within 7-14 days of discharge.
- Follow-up appointments for high-risk patients are booked before discharge, taking transportation and caregiver's schedules into account.
- A follow-up phone call or visit for high-to-moderate risk patients occurs within 48 hours of discharge to assess ability to manage care.
- Collaboration occurs with Most Responsible Provider regarding discharge and follow-up plan.
- The timeliness of and level of care continuity post-transition are evaluated.

Evidence

- Incremental Benefit of a Home Visit Following Discharge for Patients with Multiple Chronic Conditions Receiving Transitional Care - *Jackson, Carlos et al. Population Health Management 19.3 (2016): 163–170. PMC. Web. 10 Sept. 2018.*
- Comprehensive discharge follow-up in patients' homes by GPs and district nurses of elderly patients - *Rytter, Lars et al. Scandinavian Journal of Primary Health Care 28.3 (2010): 146–153. PMC. Web. 10 Sept. 2018.*
- The Impact of Post-discharge Telephonic Follow-Up on Hospital Readmissions - *Harrison, Patricia L. et al. Population Health Management 14.1 (2011): 27–32. PMC. Web. 10 Sept. 2018.*
- Discharge planning and home follow up by advanced practice nurses reduced hospital readmissions of elderly patients - *Naylor MD, Brooten D, Campbell R, et al. Comprehensive discharge planning and home follow-up of hospitalized elders. A randomized clinical trial. JAMA 1999 Feb 17; 281:613–20*

Improvement Inspiration and Resources

- Cases and Commentaries: Post Discharge Follow Up Phone Calls – *Agency for Healthcare Research and Quality*
- Tool: How to Conduct a Post-Discharge Follow-up Phone Call - *Agency for Healthcare Research and Quality*
- Tool: After Hospital Care Plan - *Agency for Healthcare Research and Quality*
- Change Package: Timely post discharge follow-up phone calls to follow-up on symptoms and review the care transition plan (Page 12) - *Health Research & Educational Trust*

Data Available in Saskatchewan

Average time from transition out of hospital to first contact with community care, Third Next Available Appointment in Community, % of patients with follow up appointments in place prior to discharge

Domain 6:
Social and Community Supports

Background

To improve our health as a population, we need to look beyond the boundaries of our health care system. To achieve a seamless, integrated, and person-centered system, new partnerships and relationships will need to be built between hospital teams, community teams, and other health/social organizations that operate outside of – but parallel to – the health care system.

Partnerships between hospitals and community/social agencies may be different in each community depending on the needs of the population, but there are many examples of programs and services that are working to connect care across hospitals and communities more effectively.

Leading Operational Practices:

- Needs are assessed and community support services outside of the health care system are considered in transition planning.
- Care services and organizations outside of health care system are enlisted as partners in care in a standardized way (i.e. referral processes).

Evidence

- Creating Effective Hospital Community Partnerships to Build a Culture of Health - *Health Research & Educational Trust. (2016, August). Chicago, IL: Health Research & Educational Trust.*
- Hospital-based Strategies for Creating a Culture of Health - *Health Research & Educational Trust. (2014, October). Chicago, IL: Health Research & Educational Trust*

Improvement Inspiration and Resources

- Community Partnership Resource Guide – *Quality Improvement and Innovation Partnership, Government of Ontario, 2010*
- Mount Sinai Hospital Community Partnership Strategy, *Toronto, Ontario*
- Ile-a-la-Crosse Community Mobilization Program – *Saskatchewan Health Authority*
- Primary Driver: Collaborate with providers and agencies across the continuum (page 16-18) - *Health Research & Educational Trust (February 2017). Preventable Readmissions Change Package: 2017 Update. Chicago, IL*
- Integrated Comprehensive Care - *St. Joseph's Healthcare, Hamilton, ON*
- Video: Joined Up Care - Sam's Story – *The King's Fund*
- Program: Nottingham CityCare Partnership
- QI Power Hour Presentation: Hub Tables in Saskatchewan

Domain 7:
Information Flow (Completeness, Continuity, and Timeliness)

Background

The timely flow of accurate, relevant information is critical to patient safety and effective care transitions. Patients and providers should have the information they need, when they need, in a format they can use and understand.

Leading Operational Practices:

- Information shared at care transitions is documented.
- Documentation tools and communication strategies are used to standardize information transfer at care transitions.
- During care transitions, clients and families are given information that they need to make decisions and support their own care.
- The effectiveness of communication is evaluated and improvements are made based on feedback received.
- Discharge summaries are reliably transmitted to post-discharge providers within 48 hours.

Evidence

- Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians - *Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. JAMA. 2007;297(8):831–841.*
- Novel combined patient instruction and discharge summary tool improves timeliness of documentation and outpatient provider satisfaction - *Gilliam, Meredith et al. SAGE Open Medicine 5 (2017): 2050312117701053. PMC. Web. 10 Sept. 2018.*
- An Australian discharge summary quality assessment tool: A pilot study - *Mahfouz , C., Bonney, A., Mullan, J. & Rich, W. (2017). Australian Family Physician, 46 (1-2), 57-63.*

Improvement Inspiration and Resources

- Transcription Dictation in Saskatoon - *Saskatchewan Health Authority*
- Recommendations for the future version of electronic discharge summary at Nova Scotia Health Authority - *Salunkhe, Arun, Internship report submitted in partial fulfillment of the requirements of Master in Health Informatics Program, Dalhousie University, Faculty of Computer Science, Halifax*

Domain 8:
Functional Decline Prevention

Background

Hospitalizations are not without risk – particularly for older adults. During hospital stays, adverse events such as medication errors, falls, delirium, and infections often occur. Although patient safety in acute care has been a provincial priority in recent years, little attention has been paid to how a patient's functional decline contributes to length of stay, unnecessary hospital/ALC days, and premature admission into long-term care.

Leading Operational Practices:

- Risk assessment tools are used to identify patients/clients at risk for functional decline.
- Care teams are actively working to prevent decline in patient/client mobility and self-care.
- Care teams are actively working to prevent decline in patient/client cognition and emotional health.

Evidence

- Reducing Functional Decline in Hospitalized Elders - *Kleinpell RM, Fletcher K, Jennings BM. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 11.*
- Integrated approach to prevent functional decline in hospitalized elderly: the Prevention and Reactivation Care Program (PReCaP) - *deVos et al. BMC Geriatrics201212:7*
- Improving patient safety for older people in acute admissions: implementation of the Frailsafe checklist in 12 hospitals across the UK - *Papoutsi et al., Age and Ageing, Volume 47, Issue 2, 1 March 2018, Pages 311–317*

Improvement Inspiration and Resources

- Quick Guide: Discharge to Assess - *NHS England*
- The Mobilization of Vulnerable Elders (MOVE) - Regional Geriatric Program of Toronto
- Hamilton Health Sciences Hospital Elder Life Program (HELP) (and related CBC story)
- Senior Friendly Hospitals in Ontario
- ALC Avoidance Leading Practices and Improvement Strategies for the Acute Care - *Toronto, ON*
- Mobility Change Package and Toolkit - *Hospital Elder Life Program*

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