

Quality  
Standards

# Transitions Between Hospital and Home

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Care for People of All Ages



**Ontario Health**  
Quality

# About This Quality Standard

The following quality standard addresses **care for people of all ages transitioning (moving) between hospital and home after a hospital admission**. The transition from hospital to home is commonly referred to as a “hospital discharge.”

This quality standard focuses on people who have been admitted as inpatients to any type of hospital, including complex continuing care facilities and rehabilitation hospitals.

## What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They:

- Help patients, families, and caregivers know what to ask for in their care
- Help health care professionals know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

Quality standards are developed by the Quality business unit at Ontario Health, in collaboration with health care professionals, patients, and caregivers across Ontario.

For more information, contact [qualitystandards@hqontario.ca](mailto:qualitystandards@hqontario.ca).

# Values That Are the Foundation of This Quality Standard

This quality standard was created, and should be implemented, according to the [Patient Declaration of Values for Ontario](#). This declaration “is a vision that articulates a path toward patient partnership across the health care system in Ontario. It describes a set of foundational principles that are considered from the perspective of Ontario patients, and serves as a guidance document for those involved in our health care system.”

These values are:

- Respect and dignity
- Empathy and compassion
- Accountability
- Transparency
- Equity and engagement

Health care professionals should acknowledge and work towards addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples throughout Canada. This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities. This quality standard uses existing clinical practice guideline sources developed by groups that may not include culturally relevant care or acknowledge traditional Indigenous beliefs, practices, and models of care.

# Quality Statements to Improve Care

These quality statements describe what high-quality care looks like for people as they transition between hospital and home.

## Quality 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.

## Quality 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.

## Quality 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.

## Quality 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.

## Quality 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.

## **Quality 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.

## **Quality 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.

## **Quality 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.

## **Quality 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.

## **Quality Statement 10: Out-of-Pocket Costs and Limits of 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.

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# Scope of This Quality Standard

This quality standard addresses care for people of all ages transitioning (moving) between hospital and home after a hospital admission. The transition from hospital to home is commonly referred to as a “hospital discharge.” 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 scope of this quality standard includes all clinical populations, including groups that often face challenges with transitions, such as people with complex care, mental health, addictions, palliative, or end-of-life care needs. The scope also includes all health care providers.

Although many of the statements may apply to them, this quality standard does not address the specifics of:

- Transitions between inpatient mental health settings and home
- Transitions from the emergency department to home
- Postnatal care for healthy, stable mothers and infants returning home
- Patients with an Alternate Level of Care (ALC) designation

This quality standard does not address:

- Transitions from children’s to adults’ services
- Inter- and intra-hospital transitions

## Why This Quality Standard Is Needed

Care transitions occur when patients transfer between different care settings (e.g., hospital, primary care, long-term care, home and community care) and between different health care providers during the course of an acute or chronic illness.

Transitions are critical and vulnerable points in the provision of health care.<sup>1</sup> Transitions between hospital and home are complex, multiple-step processes that require integrated communication and coordination among the patient, their caregivers, the hospital team, primary care, and home and community care providers.<sup>2</sup>

#### WHY THIS QUALITY STANDARD IS NEEDED CONTINUED

The transition process is further complicated by the complexities of the health system because care is delivered by multiple providers with various levels of accountability.<sup>3</sup> As a result, there are many points at which communication and care processes can break down. These include, but are not limited to<sup>4,5</sup>:

- Preparing family and caregivers for the person's return home
- Communicating the person's care plan to the health care providers taking over the person's care
- Performing medication reconciliation and checking post-discharge medication adherence
- Arranging for transportation and equipment needs at home
- Coordinating appropriate follow-up care (e.g., medical appointments, home and community care services)

When patients' care transitions are not managed well, patients may suffer harm from errors and delays in care. Either can result in avoidable hospital admissions, emergency department visits, and increased health care costs. They can also negatively affect patients' experiences.<sup>1,3,4,6-13</sup> Some patients may feel emotional distress and worsening of symptoms, and family and caregivers may also experience distress.<sup>5,14,15</sup>

There are opportunities for improvement in Ontario to ensure seamless transitions between hospital and home. For example, recent reports and surveys found that:

- About 25% of respondents reported that their primary care providers were not aware of the care they had received in hospital<sup>16</sup>
- Only 59% of people discharged from hospital were aware of which danger signs to look out for at home, and only 52% knew when to resume their usual activities<sup>17</sup>
- Although 80% reported knowing how to take their medications, 36% did not know what side effects to watch for<sup>17</sup>
- One-third of people discharged from hospital for a mental health or addictions condition did not have a follow-up visit with a physician within 7 days after discharge<sup>16</sup>
- Less than half of people hospitalized with serious chronic conditions had follow-up visits with a doctor within 7 days of leaving hospital<sup>16</sup>; this is an important finding, given that about 20% of people with serious chronic conditions are readmitted to hospital within 30 days after discharge<sup>17</sup>
- As many as 44% of patients in Ontario do not attend suggested post-discharge appointments for follow-up medical care because of issues such as mobility limitations, low health literacy, financial concerns, and a lack of social supports<sup>18,19</sup>



#### WHY THIS QUALITY STANDARD IS NEEDED CONTINUED

Further, information is not consistently transferred between health care providers. The Change Foundation reports that many community-based service providers regularly rely on patients and informal caregivers to pass on relevant information to other providers.<sup>20</sup> Addressing these gaps in information flow can help people stay safe at home and avoid unnecessary return visits to hospital.

A 2017 report highlighted systemic barriers that family doctors in Ontario often face when coordinating care for their patients in home and community care<sup>21</sup>:

- Less than a third of family doctors say their practice routinely communicates with their patients' community case managers or home care providers about their patients' needs and services
- About 30% of Ontario family doctors say they sometimes, rarely, or never receive a notification when their patient is discharged from hospital

A 2017 report from the Ontario Patient Ombudsman identifies several opportunities to improve the quality of patients' experiences as they prepare for discharge and transition between hospital and home, and states that the key to improvement is accurate, timely communication and engagement with patients and their caregivers.<sup>22</sup> Patients and their families and caregivers are the constant in transitions and are crucial to any strategies that support safe and effective transitions.<sup>23</sup>

Some patients transitioning between hospital and home are particularly vulnerable and at increased risk of hospital readmissions, such as people with complex care needs (including children and older people with multiple comorbidities or cognitive impairment).<sup>24-28</sup> The needs of children and youth—especially those with complex medical conditions or mental health and addiction issues—are different from those of adults, and their special needs must be taken into consideration when planning transitions between hospital and home.

Those who are medically underserved, have low socioeconomic status,<sup>29</sup> or are members of specific populations (e.g., Indigenous Peoples, newcomers to Canada, refugees, and the homeless) face several barriers to care, including few programs and resources in preferred languages and a lack of culturally safe care.<sup>30</sup> Some of these populations are also disproportionately affected by poverty, trauma, and social isolation, which can, in turn, reduce the effectiveness of care transitions. These people may need access to additional resources and increased collaboration with community partners and social services.

To support the development of this quality standard on transitions between hospital and home, our organization partnered with health care and community organizations to conduct a province-wide consultation through broad engagement with people with lived experience of transitions from hospital to home. What we heard from patients is summarized in Appendix 4.

# How to Use This Quality Standard

Quality standards inform patients, clinicians, and organizations about what high-quality care looks like for health conditions or processes deemed a priority for quality improvement in Ontario. They are based on the best evidence.

Guidance on how to use quality standards and their associated resources is included below.

## For Patients

This quality standard consists of quality statements. These describe what high-quality care looks like for people as they transition between hospital and home.

Within each quality statement, we've included information on what these statements mean for you, as a patient.

In addition, you may want to download this accompanying [patient guide](#) about going home from the hospital, to help you and your family have informed conversations with your health care providers. Inside, you will find questions you may want to ask as you work together to make a plan for your care.

## For Clinicians and Organizations

The quality statements within this quality standard describe what high-quality care looks like for people as they transition between hospital and home.

They are based on the best evidence and designed to help you know what to do to reduce gaps and variations in care.

Many clinicians and organizations are already providing high-quality evidence-based care. However, there may be elements of your care that can be improved. This quality standard can serve as a resource to help you prioritize and measure improvement efforts.

Tools and resources to support you in your quality improvement efforts accompany each quality standard. These resources include indicators and their definitions (Appendix 2) to help you assess the quality of care you are delivering, and identify gaps in care and areas for improvement. While it is not mandatory to use or collect data when using a quality standard to improve care, measurement is key to quality improvement.

There are also a number of resources online to help you, including:

- Our [patient guide](#) on going home from the hospital, which you can share with patients and families to help them have conversations with you and their other health care providers. Please make the patient guide available where you provide care
- Our [measurement resources](#), which include our data tables to help you identify gaps in care and inform your resource planning and improvement efforts; our measurement guide of technical specifications for the indicators in this standard; and our “case for improvement” slide deck to help you to share why this standard was created and the data behind it
- Our [Getting Started Guide](#), which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- [Quorum](#), an online community dedicated to improving the quality of care across Ontario. This is a place where health care providers can share information and support each other. It includes tools and resources to help you implement the quality statements within each standard
- [Quality Improvement Plans](#), which can help your organization outline how it will improve the quality of care provided to your patients, residents, or clients in the coming year

While you implement this quality standard, there may be times you find it challenging to provide the care outlined due to system-level barriers. Appendix 1 provides our recommendations to provincial partners to help remove these barriers so you can provide high-quality care. In the meantime, there are many actions you can take on your own, so please read the standard and act where you can.

## How to Measure Overall Success

The Transitions Between Hospital and Home Quality Standard Advisory Committee identified some overarching goals for this quality standard. These goals were mapped to indicators that can be used to monitor the progress being made to improve transitions from hospital to home in Ontario. Some indicators are provincially measurable, while one can be measured using only locally sourced data.

Collecting and using data associated with this quality standard is optional. However, data will help you assess the quality of care you are delivering and the effectiveness of your quality improvement efforts.

We realize this standard includes a lengthy list of indicators. We've given you this list so you don't have to create your own quality improvement indicators. We recommend you identify areas to focus on in the quality standard and then use one or more of the associated indicators to guide and evaluate your quality improvement efforts.

See Appendix 2 for additional details on how to measure these indicators, and our [measurement guide](#) for more information and support.

## Indicators That Can Be Measured Using Provincial Data

- Percentage of people discharged from hospital to home who report feeling that they were involved in decisions about their care and treatment as much as they wanted to be
- Percentage of people discharged from hospital to home who report that the doctors or staff where they usually get medical care seem informed and up to date about the care they received in hospital
- Percentage of people discharged from hospital to home who received home care and community support services who report that their home care started when they needed it
- Median and mean wait times from hospital discharge to first home care service date for people newly approved for home care services
- Percentage of people discharged from hospital whose primary informal caregiver reports feeling prepared for the role of caregiving (measurable for caregivers of home care clients only)
- Percentage of people discharged from hospital to home who visit the emergency department within:
  - 7 days after discharge
  - 30 days after discharge
- Percentage of people discharged from hospital to home who are readmitted to hospital within:
  - 7 days after discharge
  - 30 days after discharge

## Indicator That Can Be Measured Using Only Local Data

- Percentage of people discharged from hospital to home whose discharge summaries are delivered to primary care providers within 48 hours after discharge from hospital

# **Quality Statements to Improve Care: The Details**

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# 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.

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**Sources:** National Institute for Health and Care Excellence, 2015<sup>31</sup> | Registered Nurses' Association of Ontario, 2014<sup>33</sup>

### Definitions

**Home and community care providers:** Health care providers based in the community; home care and community support service providers, care coordinators, staff at community service organizations; staff at community agencies for mental health and addiction services; managers or health care providers at long-term care facilities or hospices; and community pharmacists. (See also the definition of “home care and community support services” in quality statement 9.)

**Relevant information:** When transferring a patient from the community to the hospital or when notified of a patient’s admission to hospital, primary care and home and community care providers, as well as any relevant specialist physicians, should give the admitting team all relevant information.<sup>31</sup> This information could include, but is not limited to:

- A cumulative patient profile (i.e., summary of the patient’s medical conditions, medical history, current medications [including indication for use, dosage, frequency, and route of administration], allergies, family history, and social history)
- Existing care plans or individualized care plans, with specific care goals informed by the patient and their caregivers

# 1

## Information-Sharing on Admission

- Recent investigations
- The person’s ability to communicate
- The person’s linguistic background
- The person’s cultural background
- The person’s health status (physical, cognitive, and mental health)
- Sociodemographic characteristics that may affect the person’s health care needs
- Information about the person’s needs and wishes
- Behavioural issues that may need to be addressed
- Contact information for caregivers or any substitute decision-makers appointed under a “Power of Attorney for Personal Care”
- Housing status
- Preferred places of care
- Advance care planning (i.e., the person’s expressed wishes for future health and personal care, as well as identified goals of care<sup>32</sup>; see “Advance Care Planning—Substitute Decision-Maker” in our quality standard [Palliative Care](#))

In circumstances where patients are being transferred for acute concerns that are likely to be addressed quickly, much of the above information might not need to be conveyed.

**Timely:** Primary care and home and community care providers, and any relevant existing specialist physicians, should provide relevant information to the admitting team ideally within 3 business days. Sometimes information is required within 1 business day (e.g., when not having information would present a risk of harm). In these situations, the admitting team should contact the providers in the community via telephone. When transferring a patient from the community to the hospital, relevant information should be shared at the time of transfer.

# 1

## Information-Sharing on Admission

### Rationale

Clear communication and information-sharing among providers in the community and those in hospital support smooth transitions for patients between hospital and home.<sup>31</sup> Providers in the community include primary care and home and community care providers as well as any relevant specialist physicians. Yet these providers in the community are often not informed that their patients or clients have been admitted to hospital. As they have key information that can assist with the patient's care in hospital and support their transition to home, providers in the community should receive real-time electronic notification of a patient's admission to hospital, diagnoses, and predicted discharge date. In return, they should provide relevant information to the hospital admitting team, ideally within 3 business days.

In order to facilitate information-sharing, hospital and primary care and home and community care providers, and relevant specialist physicians, should have each other's contact information. Relevant information should be transferred electronically via electronic health records, secure email, or secure messaging.

When the hospital team and providers in the community are engaged early in the hospital admission process, patients and caregivers do not have to repeat the same information multiple times to different providers.<sup>31</sup> Further, clear communication among care providers ensures that the onus of sharing important information is not put on the patient or caregivers. Clear communication among providers during the admission process can also improve people's experiences in hospital, because the hospital admitting team is given a range of information about people's needs, wishes, and circumstances.

Upon their admission to hospital, consent from the patient (or their substitute decision-makers) to share relevant information within their circle of care may be implied. This depends on the person's circumstances, and is according to local organizational policies and procedures, health regulatory colleges of Ontario, and compliance with Ontario's privacy law, the *Personal Health Information Protection Act of 2004 (PHIPA)*.<sup>34</sup>



# 1

## Information-Sharing on Admission

### What This Quality Statement Means

#### For Patients

When you are admitted to the hospital, hospital staff should ask you:

- The name of your family doctor or nurse practitioner and any specialists
- The name of any other health care providers you have outside the hospital, such as a home care nurse or therapist, community pharmacist, or other home and community care provider

The hospital should let these care providers know that you have been admitted to the hospital and give them information about the care you receive while you are there.

Your family doctor or nurse practitioner and any applicable home care and community support service providers should share any important information they have about your health with the hospital. This communication will help you receive the best possible care while you are in the hospital and when you leave.

#### For Clinicians

*If you are a hospital-based provider on the admitting team, notify the patient's primary care and home and community care providers, as well as relevant specialist physicians, of the patient's admission to hospital, their diagnoses, and their predicted discharge date via real-time electronic notification. If the patient is not currently a client of home and community care but will need a referral to such services, the hospital should notify the relevant service providers as soon as this decision is made. (See the definition of "home care and community support services" in quality statement 9.)*

*If you are a primary care or home and community care provider or relevant specialist physician, share all available relevant information with the admitting team when you arrange for, or are notified of, a hospital admission for one of your patients or clients. Share information in a timely manner.*

# 1

## Information-Sharing on Admission

### For Health Services Planners

Ensure that hospitals have systems, processes, and resources in place to notify the patient's primary care and home and community care providers, as well as relevant specialist physicians, of the patient's admission to hospital, their diagnoses, and their predicted discharge date via real-time electronic notification.<sup>35</sup>

Ensure that systems, processes, and resources are in place to allow hospital teams and providers in the community to share information with each other. Ensure that clear instructions and relevant contact information are provided to providers in the community regarding how to share information with the hospital (e.g., a portal for transferring relevant information from electronic health records, or a phone number).

### QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

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- Percentage of people discharged from hospital whose hospital notifies their primary care and home and community care providers and relevant specialist physicians about the hospitalization soon after admission
- Local availability of integrated electronic health records that allow hospital teams and primary care and home and community care providers and relevant specialist physicians to share information with each other

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

# 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.

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**Sources:** National Institute for Health and Care Excellence, 2015<sup>31</sup> | Registered Nurses' Association of Ontario, 2014<sup>33</sup>

### Definitions

**Comprehensive assessment:** An individualized assessment of a person's current and evolving health care and social support needs, including all relevant information shared on admission (see quality statement 1). It should be started early upon the person's admission to hospital by the interprofessional team, engaging with primary care and home and community care providers, as well as relevant specialist physicians, and updated regularly to inform the patient's transition plan.

A comprehensive assessment consists of, but is not limited to:

- The person's presenting health, developmental, and social concerns, as well as any caregiver concerns
- The person's current housing situation
- The person's current and evolving care requirements on admission
- A medication review (see quality statement 7)
- An evaluation of the person's clinical functional status
- The person's cognitive and psychological status
- Any assessments for mental health conditions or addictions
- The person's ability to manage activities of daily living (e.g., personal care, walking) and instrumental activities of daily living (e.g., housework, preparing meals, shopping, managing medications)
- The person's degree of health literacy
- An assessment for geriatric syndromes, including falls, immobility, delirium or dementia, polypharmacy, incontinence, and end-of-life care,<sup>36</sup> if the person is an older adult or at risk

## 2

### Comprehensive Assessment

- Names and contact information for the person’s caregivers, their substitute decision-makers, and other people involved in their social support circle
- Any advance care planning needs (see the definition of “relevant information” in quality statement 1)
- The need for assessments of eligibility for health and social care funding
- Identification of the person’s risk factors for a complex transition or readmission; this could include, but is not limited to<sup>31</sup>:
  - Palliative care needs
  - Homelessness
  - A lack of suitable placement in a care home
  - Reduced cognitive ability
  - Safeguarding issues (i.e., risk of self-harm or any circumstances in the person’s life that may put their personal safety at risk; for example, abuse or neglect)
  - Cultural safety

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<sup>37</sup> or the LACE index<sup>38</sup>).

**Health care needs:** A person’s treatment, care, or aftercare needs that they receive for a disease, illness, injury, or disability. These needs may be addressed through diet, medical care, nursing, occupational therapy, pharmacy, physiotherapy, respiratory therapy, social work, speech-language therapy, or mental health or addiction services.

**Social support needs:** These arise when people live in complex social circumstances (e.g., complex family dynamics, living alone, low income, unstable housing) or have complex health issues (e.g., cognitive impairment, an addiction, or a mental health condition, or face insufficient caregiver availability or capacity). These needs may be met through community support services, housing and social services, or other funding sources.

**Updated regularly:** Updated as the person's condition changes throughout the hospital stay.

**Transition plan:** A document that describes the coordination of care and support needs for a person's transition from hospital to home (see quality statement 5).

## Rationale

A comprehensive assessment of a patient's needs goes beyond a clinical examination. It also considers their current and evolving health care and social support needs, considering the patient as a whole person. A comprehensive assessment takes into account any physical, mental health, addictions, or social challenges the person may face.<sup>39</sup>

The assessment should be initiated by the hospital team early upon the patient's admission to hospital (or at pre-admission for planned admissions) and should be developed by and shared with the patient's hospital and primary care and home and community care providers, as well as relevant specialist physicians. This assessment helps to anticipate any post-hospitalization health care or social support needs the person may have and to establish an initial transition plan. If comprehensive assessments are not done upon admission, or if individual assessments are not used to inform their transition plans, this can result in the patient having a longer hospital stay, unnecessary readmissions, and a poorer experience.<sup>33</sup>

Older people and children and adults with complex care needs make up a substantial portion of hospital admissions. Many have multiple chronic conditions that can lead to complex medical, functional, psychological, and social needs.<sup>24-27,40</sup>

Vulnerable populations, including people with low socioeconomic status and those who are medically underserved, may also experience more adverse events after discharge from hospital.<sup>29</sup> Individualized comprehensive assessments help health care providers identify people who may be at risk, coordinate health and social support services for those who need them, and develop long-term plans to manage patients' transition needs.

## What This Quality Statement Means

### For Patients

Shortly after you are admitted to the hospital, health care professionals should ask you and your caregivers about:

- Your health
- Your ability to function at home and at school or work
- Any other issues that affect your health

This is called a comprehensive assessment. The people taking care of you in the hospital will use this information to make sure you receive the best possible care while you are in the hospital and after you return home.

### For Clinicians

Initiate a comprehensive assessment (see definition) shortly after people are admitted to hospital and update the assessment regularly throughout the hospital stay. Identify people who are at risk for a complex transition (e.g., older people, people with multiple comorbidities, people with complex social circumstances), coordinate health and social support services for those who need them, and develop long-term plans to manage people's transition needs.

Work with primary care and home and community care providers and relevant specialist physicians who often know the clients well and can provide pre-admission details and identify factors that could prevent a safe, timely transition between hospital and home.

### For Health Services Planners

Ensure that hospitals have systems, processes, and resources in place to initiate a comprehensive assessment early upon a person's admission to hospital and to update the assessment regularly throughout the hospital stay.

### QUALITY INDICATOR: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

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- Percentage of people discharged from hospital to home whose comprehensive assessment was updated regularly throughout their hospital stay

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

# 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.

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**Sources:** Concept Mapping Patient Experience Research<sup>5</sup> (see also Appendix 4) | National Institute for Health and Care Excellence, 2015<sup>31</sup>

### Rationale

The patient, family members, and other informal caregivers all play an essential role in the patient's transition planning. They can provide information about the patient's life and needs, including relevant circumstances beyond the patient's medical condition and physical needs.<sup>31</sup> When the patient returns home, family members and caregivers are often involved in providing care (e.g., wound care, giving medications) and helping with activities of daily living (e.g., meal preparation, transportation to follow-up appointments). They also watch for worrisome signs and symptoms, and advocate for the patient. It is therefore important that they are involved early in discussions about the patient's transition plan to ensure that decisions respect the patient's values, preferences, and expressed needs, as well as their own.<sup>41</sup>

However, for family members and caregivers to be involved in transition planning, the patient must consent to include them in their circle of care (see Glossary). Sometimes, an ethicist may need to be involved for issues such as consent, capacity, and complex transitions.

# 3

## Patient, Family, and Caregiver Involvement in Transition Planning

It is also important to consider that family members and caregivers can experience strain, anxiety, and stress in their role supporting patients.<sup>15,31</sup> Health care professionals sometimes assume that family members or caregivers will provide support to the patient following their transition from hospital to home without ensuring their capacity to do so.<sup>5,31</sup> Family members and caregivers are also sometimes young. It is important that health care professionals respect the role of these individuals and include them in all aspects of transition decision-making.

The involvement of patients, family members, and caregivers in the patient's transition planning should be culturally appropriate, and efforts should be made to address the needs of all those involved (e.g., by assisting people with physical, sensory, or learning disabilities or by providing translations for those who do not speak or read English; or by accommodating their working and family responsibilities) so that they can effectively contribute to the plan. When needed, an interpreter or advocate or involvement of community and social services should be made available. It also important to ensure that children and youth themselves are involved in the transition process.

### **What This Quality Statement Means**

#### **For Patients**

Before you leave the hospital, you should be involved in all decisions about your transition from hospital to home. This makes sure that your wishes, needs, and preferences are considered. If you want them to be involved, your family and caregivers can also be part of these decisions.

#### **For Clinicians**

Ensure that patients are involved in transition planning. If patients consent to their involvement, family members and caregivers should also be involved, as they are important sources of information about patients' needs. Consider the willingness and capacity of family members and caregivers to provide support at home to ensure the patients' support



# 3

## Patient, Family, and Caregiver Involvement in Transition Planning

needs will be met once they return home, and identify any needs for caregiver respite. For patients without family members or caregivers involved in their care, make appropriate arrangements to ensure patients' needs will be met once they return home.

### For Health Services Planners

Ensure that hospitals have systems, processes, and resources in place to enable the involvement of the patient, family, and caregivers in transitions planning.

### QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

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- Percentage of people discharged from hospital to home who report feeling that they were involved in decisions about their transition planning as much as they wanted to be
- Percentage of people discharged from hospital to home who report feeling that their family and caregivers were involved in decisions about their transition planning as much as they wanted to be

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

# 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.

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**Sources:** Concept Mapping Patient Experience Research<sup>5</sup> (see also Appendix 4) | National Institute for Health and Care Excellence, 2015<sup>31</sup> | Registered Nurses' Association of Ontario, 2014<sup>33</sup>

### Definitions

**Education, training, and support:** Education should be tailored to the individual needs of the patient or caregiver and provided in a variety of formats, including verbal (through face-to-face meetings or phone calls, including Telehealth), written, or electronic, using plain language and visual tools. Training may be hands-on or simulation-based. Examples of hands-on training include how to use medical equipment and devices, administer medication, change bandages or dressings, provide enteral feedings, or transfer the patient from one position to another. The “teach-back” method can be used to confirm patient or caregiver understanding. In this method, the trainer asks the trainee to explain what they have been taught.

This practical support and advice may be provided in hospital and continue in the community once the person is home. Hospital providers, primary care and home and community care providers, and relevant specialist physicians should collaborate to ensure support and advice are consistent and reinforced in the community.

# 4

## Patient, Family, and Caregiver Education, Training, and Support

Before being discharged, the patient and family or caregiver should be given important information and care instructions, such as:

- A list of medications, how to use them, and what they are used for (see quality statement 7)
- Self-care instructions for both the patient and caregiver
- Contact information for a health care professional who can provide answers to questions
- Warning signs and symptoms to watch out for, including which signs and symptoms should prompt a call to a health care professional and which require a visit to the emergency department
- Changes to the patient's routine when they return home, including changes to diet and physical activity
- Follow-up appointments, including location, date, time, and confirmation of bookings, or whom to call if appointments are needed but have not yet been scheduled

Information about resources to support patients and caregivers should be shared verbally and in a written format with the patient and caregivers (e.g., via a patient-oriented discharge summary, or PODS<sup>42</sup>) before they leave the hospital. Examples of these resources include community-based services, family support services or groups, peer supporters, and respite care.

**Health care needs:** A person's physical, functional, social, cognitive, and mental health needs, all of which should be considered in their care.

### Rationale

Hospitalization is stressful for patients, families, and caregivers, and the move from hospital to home can be a time of heightened stress, as many important care instructions are given to them at this time.<sup>43</sup> Building patient and caregiver capacity to manage patient care at home should begin during the patient's hospital stay and continue in the community when they transition home.<sup>31</sup>

Patients and their families and caregivers want to know exactly what to do once the patient is home (e.g., what medications to take and when, how to manage any medical equipment that is needed) and whom to contact if questions or unexpected symptoms

# 4

## Patient, Family, and Caregiver Education, Training, and Support

arise.<sup>5</sup> Receiving clear instructions, contact information for a health care professional, and information about relevant community resources can ease anxiety and provide comfort. This information can also help the patient with their recovery and to avoid potential harm.<sup>5,43</sup>

If a patient is transitioning to a long-term care facility or hospice, the receiving health care team should also be given information about any changes to the patient's care plan and any new equipment.

### **What This Quality Statement Means**

#### **For Patients and Caregivers**

Before you leave the hospital, your health care team should help you learn how to manage your care at home, including how to take medications and use medical equipment. Ask your care team for written instructions.

Here are some important things to know:

- What medications you need, how to take them, and what they're for
- How you might feel and what activities you can do once you're at home again
- What symptoms mean and when you should call a health care professional or go to the emergency department
- Any changes you need to make to your daily routine
- What follow-up appointments have been scheduled for you
- Where to go for more information or resources to support you

Your hospital care team can share this information verbally and in a written format (e.g., via a patient-oriented discharge summary, or PODS<sup>42</sup>). You may also get hands-on training for things like how to take medications, change bandages, or use medical equipment.

# 4

## Patient, Family, and Caregiver Education, Training, and Support

### For Clinicians

Provide education and training to patients and caregivers that will allow them to care effectively for themselves or the people they are supporting at home. Tailor the information and training to the patient's needs, their perception of their health condition, their cognitive ability, and their stage of readiness to care for themselves, as well as to the needs of family members and caregivers and their willingness and capacity to provide care for the patient.

Ensure that information and training are culturally appropriate and accessible to all involved (e.g., by accommodating physical, sensory, or learning disabilities or by providing translations). When needed, ensure an interpreter or advocate is available.

Identify patients who do not have family or caregiver support, and make plans for additional support for them, if needed.

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. Ensure that primary care and home and community care providers and relevant specialist physicians are aware of the information and support provided (e.g., additional education and training if needed).

### For Health Services Planners

Ensure that hospitals have systems, processes, and resources in place to provide education, training, and support in response to the individual needs of patients heading home, as well as those of their families and caregivers.

### QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

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- Percentage of people discharged from hospital to home (and their caregivers) who report having received enough information about what to do if they are worried about their health condition or treatment after leaving the hospital
- Percentage of people discharged from hospital to home who report feeling they have the support and services they need to help them manage their health condition at home
- Percentage of people discharged from hospital to home who report knowing whom to contact if they have a question about their health condition or treatment
- Percentage of people discharged from hospital to home whose primary informal caregiver reports feeling prepared for the role of caregiving (measurable for caregivers of home care clients only)

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

# 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.

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**Sources:** Advisory Committee consensus (timing) | National Institute for Health and Care Excellence, 2015<sup>31</sup> | Registered Nurses' Association of Ontario, 2014<sup>33</sup>

### Definitions

**Transition plan:** A written (printed or electronic) document summarizing the person's hospital stay, their diagnoses, interventions performed, and recommended actions (e.g., coordination of care and support for the transition from hospital to home).<sup>35,36</sup> This plan can reside within the discharge summary or be a separate document. A transition plan is a working document for the interprofessional teams involved in the person's care and should include these details, where available and relevant:

- The person's health condition
- The person's social and emotional well-being
- The person's ability to accomplish activities of daily living
- A complete list of the person's medications, including any changes made to medications during their hospital stay; this includes information about dosages, when to take medications, and what each medication is for (see quality statement 7)

# 5

## Transition Plans

- Phone numbers for a health care professional and for Telehealth that patients and caregivers can call if there are any problems once the patient is home
- Arrangements for follow-up medical care (see quality statement 8)
- Arrangements for continuing home and community care support needs, and their phone numbers
- Arrangements for continuing health support to meet the person’s needs
- Other useful community and voluntary services
- Availability of mental health crisis services in the community (e.g., walk-in clinics, phone lines, mobile response units)
- Arrangements for transportation home
- Arrangements for needed medical equipment and home modifications to be in place at the time of discharge
- Information about the person’s health care coverage and ability to pay for any out-of-pocket health care costs (see quality statement 10)
- Name of any substitute decision-makers appointed under a “Power of Attorney for Personal Care”

The patient’s transition plan should be shared with the patient (or substitute decision-makers) and all health care providers involved in their ongoing care and support. If the person consents, the plan should also be shared with family members and caregivers. All information in the plan, including explanations about medications, should be provided in a format that is easy for the person and their caregivers to understand (e.g., both verbally and written, with written material provided in plain language and translated as necessary).<sup>31</sup>

**Home and community care providers:** Health care providers based in the community; home care and community support service providers, care coordinators, and staff at community service organizations; staff at community agencies for mental health and addiction services; managers or health care providers at long-term care facilities or hospices; and community pharmacists. (See also the definition of “home care and community support services” in quality statement 9.)

## Rationale

A patient's transition from hospital to home can be complicated, as it involves many health care providers across multiple settings (e.g., community, hospital, long-term care). Patients and their caregivers report that communication is key to effective transition planning and that having enough time with their hospital providers to ask questions and actively participate in the transition process while in hospital is especially important.<sup>5</sup> The transition plan should be started early upon the patient's admission to hospital (or pre-admission for planned admissions), and primary care and home and community care providers should help to develop it (see quality statement 2). A patient's transition plan helps ensure that their transition from hospital to home is well coordinated and meets their needs, as well as the needs of their caregivers.<sup>31</sup>

Consent for sharing the transition plan may be implied within the person's circle of care<sup>34</sup> (see Glossary). Transition plans should also be shared with the person before they leave the hospital (e.g., via something called a patient-oriented discharge summary, or PODS<sup>42</sup>).

For people with complex care needs or mental health needs, it may be beneficial to have a case conference with all involved (including the patient, family, and caregivers) to discuss their needs before the transition.

Communication about discharge timing and logistics should also be included in the transition plan. This includes when and how the person will be transported home, any costs involved, the geographical distance, and the person's physical ability to get in and out of a vehicle. These factors can be especially important for people with low socioeconomic status, people who live alone but need help to function effectively, and people who have to travel a substantial distance to return home.<sup>5,29</sup> If a person is homeless, their transition plan should include guidance on housing and social service needs.<sup>31</sup>

Barriers to communication (e.g., learning disabilities; cognitive impairments; physical, sight, speech, or hearing impairments; difficulties with reading, understanding, or speaking English) can hinder a person's understanding of their transition from hospital to home and how they can be involved in planning for their transition.<sup>30</sup> Where appropriate, transition plans should include



accommodations to overcome these barriers and ensure people transitioning from hospital to home and their caregivers are involved in the transition decision-making process. Support for people with communication difficulties can include advocacy services.<sup>36</sup>

## What This Quality Statement Means

### For Patients

Your health care providers should include you in decisions about your transition from hospital to home. If you agree, your family and caregivers should also be involved. Your care team should create a written transition plan for you that explains everything you need to know about leaving the hospital and your care at home, including:

- How you will be transported home
- What medications to take, how to take them, and what they're for
- How to take care of yourself once you are at home

You should get a written copy of your transition plan (e.g., a PODS) before you leave the hospital. If you agree, your family and caregivers should also get a written copy. The plan should be easy to read and understand, and your care team should offer to explain it to you.

### For Clinicians

*If you're part of the hospital team,* include primary care and home and community care providers in developing the transition plan. Upon the person's discharge, alert their primary care and home and community care providers and relevant specialist physicians, and share the transition plan with them. Give the patient a written copy of their transition plan before they leave hospital.

Use standardized documentation tools to ensure a succinct, clear, and timely exchange of the transition plan within 48 hours of discharge.<sup>33</sup>

# 5

## Transition Plans

### For Health Services Planners

Ensure that hospitals have systems, processes, and resources in place:

- To give people transitioning from hospital to home a written copy of their transition plan before leaving hospital (e.g., via a PODS<sup>42</sup>)
- For standardized documentation and communication strategies (e.g., electronic portal) to allow for timely (within 48 hours of discharge) and clear communication of the transition plan with the person's primary care and home and community care providers and relevant specialist physicians<sup>33,35</sup>

### QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

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- Percentage of people discharged from hospital to home who were given a written transition plan before leaving hospital
- Percentage of people discharged from hospital to home whose discharge summaries are delivered to primary care providers within 48 hours after discharge from hospital
- Percentage of people discharged from hospital to home who receive home and community care, whose discharge summaries are sent to their home and community care providers within 48 hours after discharge
- Percentage of people discharged from hospital to home who report that the doctors or staff where they usually get medical care seem informed and up to date about the care they received in hospital
- Local availability of integrated electronic health records that allow hospital teams and home and community care providers to share information with each other

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

# 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.

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**Sources:** National Institute for Health and Care Excellence, 2015<sup>31</sup> | Registered Nurses' Association of Ontario, 2014<sup>33</sup>

### Definition

**Transition planning, coordination, and communication:** Establishing a set of actions designed to ensure effective coordination, communication, and continuity of health care as a patient transitions from hospital to home<sup>25</sup> may include, but is not limited to:

- Contacting the person's primary care and home and community care providers and relevant specialist physicians
- Collecting the person's comprehensive health records in order to perform their comprehensive assessment (see quality statement 2)
- Coordinating the comprehensive assessment and the patient's care in the hospital, and ensuring all members of the patient's hospital care team and providers in the community are kept informed
- Leading the development, communication, and implementation of the transition plan
- Being the contact person for patient, family, and caregivers while the patient is in hospital and soon after discharge

## Rationale

Poor coordination and communication during a person's transition from hospital to home can be stressful for patients, as well as for their families and caregivers, and can lead to poorer outcomes.<sup>31</sup> Having a health care professional as the designated transition coordinator has been shown to have a positive effect on hospital discharge processes and outcomes<sup>31,44</sup> and to result in a better overall experience for patients and caregivers.<sup>45</sup> Patients and caregivers often have questions about the transition,<sup>5</sup> so having a named individual with knowledge of the person's physical and mental health who is responsible for the transition process can help ensure that someone is always available to answer these questions.

For people with more complex care needs, all members of the hospital team and primary care and home and community care providers should be involved in transition planning and coordination. However, clearly naming a health care professional as a single point of contact for a patient's transition planning and coordination can make the transition smoother for the patient and their family and caregivers.<sup>31</sup> In some instances, this person is the patient's most responsible physician or primary physician, a nurse practitioner, a nurse, a social worker, or another health care professional. In other instances, this person may have a job title such as "transitions care coordinator," "discharge coordinator," or "patient navigator." This person should be selected based on the patient's care and support needs.<sup>31</sup>

## What This Quality Statement Means

### For Patients

When you are admitted to the hospital, a health care professional should identify the person who will plan your transition home. This person will work with you and your family and caregivers throughout your hospital stay to make sure you know what will happen and what you need to do when you return home.

# 6

## Coordinated Transitions

### For Clinicians

Ensure that a person is named as responsible for coordinating the patient's transition from hospital to home and involve this coordinator in transition-related decisions.

### For Health Services Planners

Ensure that hospitals have systems, processes, and resources in place so that patients, families, caregivers, and home and community care providers have a named contact responsible for timely transition planning, coordination, and communication.

### QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

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- Percentage of people discharged from hospital to home who had a named community-based health care professional responsible for their care coordination at the time of discharge
- Percentage of people in hospital (or their caregivers) who report they know who is primarily responsible for coordinating their discharge
- Percentage of people discharged from hospital to home (or their caregivers) who report being unable to contact their health care professional when they needed to
- Local availability of hospital systems that provide patients, families, caregivers, and home and community care providers with a named contact responsible for timely transition planning, coordination, and communication

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

## 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.

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**Sources:** Concept Mapping Patient Experience Research<sup>5</sup> (see also Appendix 4) | National Institute for Health and Care Excellence, 2015<sup>31</sup> | Registered Nurses' Association of Ontario, 2014<sup>33</sup>

### Definitions

**Medication review:** A structured critical examination of a person's medications (including their use of vitamins and minerals, herbal and natural products, over-the-counter products, or cannabis) and any drug allergies. The aim is for the health care professional and the patient to agree on the treatment plan, ensure the medication is being used effectively, minimize medication-related problems, and reduce waste.<sup>31</sup> A medication review includes medication reconciliation, adherence, and optimization.

**Medication reconciliation:** A process where health care professionals work with a patient and caregivers to accurately identify all of the patient's current medications—including the drug names, dosages, and frequency of administration—so that this information can be accurately communicated to relevant care providers throughout the patient's transition between hospital and home. It is important to capture any discrepancies and document any medications that have been added, changed, or discontinued.<sup>31</sup>

**Medication adherence:** The extent to which a person follows their medication regimen; that is, how much a person uses their medications in the way they have agreed upon with their health care professionals. Nonadherence may limit the benefits of a medication, resulting in a lack of improvement or a deterioration in health. Nonadherence may be intentional or unintentional; for example, as a result of poor recall or difficulties in understanding the medication regimen, problems taking the medications, an inability to pay for medications, or simply forgetting to take them.<sup>31</sup>

**Medication optimization:** Taking an individualized approach with the patient to their medications, to maximize benefit and minimize harm. This step addresses both prescription and nonprescription medications to ensure that all are:

- Indicated (i.e., have a reason for use)
- Effective (i.e., doing what we expect them to)
- Safe (i.e., the benefits of use exceed the risks)
- Convenient (i.e., the patient can adhere to them; this includes paying for them and taking them as intended)

## Rationale

Transitions between hospital and home often involve changes to patients' medications. It is important that patients and their families and caregivers review their medications with a health care professional before leaving hospital and transitioning home.<sup>5</sup>

These steps are also crucial to a successful transition<sup>5</sup>:

- Ensuring patients and caregivers understand what their medications are for and are confident in their ability to manage medication regimens (i.e., take them at the right times and administer them correctly)
- Considering people's ability to afford medications and providing options for those unable to afford these costs (such as the Trillium Drug Program or private insurance coverage) and support applying for help, if needed
- Ensuring patients and caregivers know how to manage pain

# 7

## Medication Review and Support

Upon their admission to hospital and at the time of their discharge, patients should have a medication review performed by their hospital pharmacist, most responsible physician, or nurse or nurse practitioner. Once home, they should have a medication review performed by one or more community-based health care professionals (e.g., their community pharmacist, primary care provider, or a home care nurse).

Patients and caregivers should be actively involved in the reviews to ensure they are aware of all aspects of the medication regimen. A medication review should also be part of the transition plan (see quality statement 5) and carefully communicated to primary care and home and community care providers to support a safe and effective transition from hospital to home.<sup>33,35,46</sup>

### What This Quality Statement Means

#### For Patients

When you arrive at the hospital, a health care professional should ask you and your caregivers what medications you are taking.

Before you leave the hospital, they should:

- Talk with you again about any changes that have been made to your medications and why, how to take them, and side effects you might experience
- Ask if you have any concerns about paying for your medications and help you find options if you aren't able to afford the cost of medication

Once you are home again, another health care professional—like your community pharmacist, family doctor or nurse practitioner, or a home care nurse—should talk with you about your medications to make sure they fully understand your medication needs.



## For Clinicians

When you complete a medication review, consider such factors as:

- The cost of medications and options for those unable to afford such costs
- Packaging instructions for those who may need assistance taking their medication (e.g., suggestion to use blister packs, pill box)
- The patient's medication schedule, particularly when caregiver support is needed to help administer medications throughout the day and night
- Whether caregiver support is available when needed for people who need assistance with their medications
- Training on how to manage complex medication regimens

*If you're a hospital-based provider, work in partnership with patients and caregivers to complete medication reviews on admission and before discharge. Include information regarding medication reconciliation, adherence, and optimization. Engage in a discussion with patients and caregivers about their ability and willingness to use their medications at home as recommended by their health care team, about supports that are available to assist with this, and about how to access medication in the community. You may need to consider the factors listed above. You may also need to provide a short-term supply of medication until a prescription can be filled.*

The medication review should also be carefully communicated to primary care and home and community care providers.

*If you're a community pharmacist, family doctor or nurse practitioner, or a home care nurse, once the patient is home, work with them and their caregivers to complete a medication review that includes information regarding medication reconciliation, adherence, and optimization.*

Review with the patient and caregivers how to use their medications effectively at home and how to access medication in the community. You may need to consider the factors listed above.

### For Health Services Planners

Ensure that hospitals have systems, processes, and resources in place for the hospital team to complete a medication review on admission and before discharge that includes information regarding medication reconciliation, adherence, and optimization, and to communicate this information to relevant community-based care providers.

Ensure that systems, processes, and resources are in place for the most responsible provider in the community to complete a medication review that includes information regarding medication reconciliation, adherence, and optimization.

### QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

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- Percentage of people discharged from hospital to home whose medications were reconciled at discharge
- Percentage of people discharged from hospital to home who have a drug-related emergency department visit or hospital readmission within 30 days after discharge
- Percentage of people discharged from hospital to home (or their caregivers) who report having a clear understanding of their prescribed medications
- Local availability of hospital systems that provide discharge medication lists and clinical indications to community-based pharmacies upon discharge, including a full list of medications and follow-up appointments

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

# 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.

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**Sources:** Concept Mapping Patient Experience Research<sup>5</sup> (see also Appendix 4) | National Institute for Health and Care Excellence, 2015<sup>31</sup>

### Definitions

**Follow-up medical care:** Care provided in the community by the patient's primary care provider and/or specialists after the patient is discharged from hospital. In some cases, especially for children and youth with mental health concerns, this may also include their primary therapist, counsellor, or case coordinator at a community agency. Consideration should be given to the mode (e.g., face to face, telephone, virtual) and time frame for follow-up care that best suit patient and caregiver needs and preferences. The care providers responsible for making any follow-up calls should be identified before people leave the hospital.

**Coordinated care:** Follow-up medical care should be scheduled before discharge, and patients and caregivers should be given contact information for these follow-ups. In some cases, patients or a family member or caregiver may book these appointments. In other cases, patients may need assistance from hospital staff. The person booking the follow-up care should consider the patient's and caregiver's schedules, as well as how to accommodate any needs related to transportation, cost, distance, or physical mobility. If the follow-up care cannot be booked before discharge, or if it is the patient's or a caregiver's responsibility to book the follow-up care themselves, clear instructions and contact information should be given to the patient and caregiver before discharge.

## Rationale

Ensuring that people see a health care professional for follow-up medical care after discharge can help them effectively manage their health conditions and identify worsening symptoms, side effects from medication changes, and self-management challenges.<sup>47</sup> Proper coordination among care providers following discharge—including follow-up medical care that is booked before discharge and the transfer of medical information among providers—is vital to ensure that people receive proper follow-up care and monitoring following their transition from hospital to home.<sup>5</sup>

Patients sometimes experience difficulties scheduling medical appointments after they are discharged from hospital.<sup>5</sup> Ensuring that both primary care and specialist appointments are scheduled before patients leave hospital and ensuring that patients and caregivers have contact information for these visits can alleviate stress and ensure patients receive the follow-up care they need.

Some patients also face challenges with transportation to get to follow-up appointments (e.g., owing to their health condition, a lack of transportation, transportation costs, or geographical barriers). Further, people living in rural and remote communities have varied access to follow-up from primary care and specialists (Discharge Abstract Database, Ontario Health Insurance Plan Claims Database, Registered Persons Database 2016; data provided by ICES September 2018).

Medical follow-up rates are lower for people discharged from small or remote hospitals, for those living in lower-income communities, and for those who have reduced access to physicians in general.<sup>48</sup> For these individuals, a phone call, virtual follow-up, or home visit from a nurse or physician is the most appropriate mode for primary care follow-up. Others who are more vulnerable and at increased risk for not getting follow-up medical care may need additional support from community partners to ensure that they get follow-up medical care within their community (e.g., at a medical clinic located within a shelter or at a community health centre).

## What This Quality Statement Means

### For Patients

Before you leave the hospital, your care team should:

- Arrange any follow-up care you need from your primary care provider or a specialist
- Give you clear written instructions and contact information for this follow-up care

Sometimes, you or a caregiver may need to book a follow-up appointment. In this case, before you leave the hospital, someone at the hospital should:

- Give you clear instructions about the appointment and who you need to call to book your appointment

### For Clinicians

Coordinate and book follow-up medical care with the patient's primary care provider and/or specialists, as needed, before discharge. Ensure that recommendations for follow-up care are included in the patient's transition plan or discharge summary (see quality statement 5). Refer patients without a primary care provider to a local system, such as a family health team, where available, or inform patients about Health Care Connect, and help them, if needed, to search for a primary care provider.<sup>3,49</sup>

# 8

## Coordinated Follow-Up Medical Care

People at high risk for readmission may need to have follow-up medical care sooner than those with a lower risk.<sup>3</sup> For patients at high risk for readmission, arrange a follow-up phone call, home visit, and/or office visit with a community-based nurse, nurse practitioner, physician assistant, or family physician, ideally within 24 to 72 hours after discharge, to ensure patients (and caregivers) are able to effectively manage their care and take their medications correctly.<sup>31,47,50</sup>

### For Health Services Planners

Ensure that hospitals have systems, processes, and resources in place to ensure that follow-up medical care can be coordinated and booked before discharge.

### QUALITY INDICATOR: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

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- Percentage of people discharged from hospital to home who had follow-up medical care appointments coordinated and booked with their primary care provider (or most responsible provider) and/or medical specialist before discharge

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

# 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.

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**Sources:** Concept Mapping Patient Experience Research<sup>5</sup> (see also Appendix 4) | National Institute for Health and Care Excellence, 2015<sup>31</sup>

### Definitions

**Assessed for home care and community support service needs:** This considers the needs of the person and their caregivers to determine the type and amount of home care and community support services they will need after leaving hospital.<sup>51</sup> Needs include those related to function, medical care, equipment, home accommodation or modification, cognition, mental health, addiction, language, culture, and social support. (An example of a tool is the InterRAI Contact Assessment.<sup>52</sup>)

The amount of support a person needs can be considered for the short and long term. Short-term support is provided over days to several weeks. Examples include postacute medical or surgical needs. Long-term support is provided for a length of time beyond several weeks. Examples include care for people with functional limitations, chronic health issues, or medically complex care needs.

The assessment should also consider the patient's ability to pay for any out-of-pocket costs.

**Home care and community support services<sup>53</sup>:** Services provided to a person in the home and community.

# 9

## Appropriate and Timely Support for Home and Community Care

Home care includes:

- Clinical health services (e.g., dietetics, medical care, mental health care, nursing, occupational therapy, palliative care, physiotherapy, respiratory therapy, social work, speech-language therapy)
- Homemaking support (e.g., help with cleaning, laundry, or meal preparation)
- Home help (e.g., home maintenance and repair)
- Personal support services and other related services

Community support services include the clinical services listed above (e.g., provided by community-based health care providers who may be publicly or privately funded) and nonclinical services, such as:

- Adult day programs
- Caregiver relief and support
- Community dining
- Friendly visiting
- Meal delivery
- Supportive housing (i.e., long-term care and retirement homes)
- Transportation assistance
- Any other services that support people to live independently in their homes

For people with complex care needs, home care and community support services include community-based case management, including follow-up and monitoring of care.



## Rationale

Appropriate referral for home care and community support services, when needed, is essential to a patient's transition from hospital to home and has been shown to reduce the rate of hospital readmissions.<sup>31,54</sup> Timely and appropriate home care and community support services help patients feel more comfortable and confident in their ability to care for themselves when they return home.<sup>5</sup>

Research about what affects the experiences of people in Ontario around the care they receive during transitions from hospital to home most commonly reflects challenges they have with home care, including the timeliness, reliability, consistency, and sufficiency of publicly funded services.<sup>5</sup> Many rely on family, friends, private services, or charities to fill the gaps. Arranging the logistics of home care—whether involving clinical health services, medical equipment or devices, personal support workers, or nonclinical support services—can often be overwhelming for patients, families, and caregivers.<sup>5</sup>

Many factors may affect the type and amount of care a person may need, including the following<sup>51</sup>:

- Social factors such as low income, unstable housing, living alone, and complex family dynamics
- Complex health issues such as mental health conditions, addiction, significant cognitive impairment, or the presence of multiple comorbidities
- Caregiver willingness and capacity to provide care

To ensure appropriate and timely support, clear communication and alignment are needed among patients and caregivers, their hospital team, their primary care provider, and other applicable home and community care providers about the home care and community support services they need.

## What This Quality Statement Means

### For Patients

If you need health care, personal support care, or assistance from other community support services once you are back home, a care coordinator should work with you and your care providers to plan and arrange the services before you leave the hospital. (These services include things like home visits from a nurse, doctor, or therapist to help with your medical care, help with preparing meals or cleaning, and help with transportation to medical appointments.)

## For Clinicians

For patients needing home care or community support services following discharge, ensure a home and community care coordinator is assigned to assess the patient's (and caregiver's) needs and to arrange for services.

*If you are the care coordinator*, be aware of the home care and community support services that are available to your patient and how to arrange for these services. Work with the patient and caregivers, their hospital team, and home and community care providers to understand the patient's goals and preferences, to regularly assess their home care and community support service needs, and to develop (or co-design) with the patient and caregivers a care plan to meet their needs and achieve their goals. Include details of the arranged services in the transition plan or discharge summary. Regularly assess the patient's need for home care or community support services.

## For Health Services Planners

Adequately resource systems and services so that people transitioning from hospital to home have timely and equitable access to the home care and community support services they need, when they need them. Work collaboratively with stakeholders, communities, and people with lived experience, using local data and evidence, to co-design home care and community support services that meet the needs of all people transitioning from hospital to home, particularly those who are socially disadvantaged or face barriers to accessing care.

## QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

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- Median and mean wait times from hospital discharge to first home care service date for people newly approved for home care services
- Percentage of people discharged from hospital to home who are referred for home care and community support services and who report receiving enough hours of home care services
- Percentage of people discharged from hospital to home who received home care and community support services who report that their home care started when they needed it

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

## Out-of-Pocket Costs and Limits of 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.

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**Source:** Concept Mapping Patient Experience Research<sup>5</sup> (see also Appendix 4)

### Definitions

**Out-of-pocket health care costs:** Costs paid by the patient for any unfunded services from home and community care providers or any unfunded home care and community support services, as well as medications, medically necessary equipment and devices, and medical supplies.

**Health care team:** Includes the patient's hospital-based, primary care, and home and community care providers, as well as home and community care coordinators and/or social workers, if needed. In some hospitals, the roles of social worker and home and of community care coordinator are performed by the same person. In other hospitals, these are separate professionals doing different pieces of this role together.

## Rationale

Patients and caregivers in Ontario who have experienced transitions from hospital to home have identified challenges related to out-of-pocket costs for medications, medical equipment and devices, transportation, and home care services.<sup>5</sup> Limited coverage and lengthy wait times for publicly funded home care and community-based services (e.g., occupational therapy, physiotherapy, respiratory therapy, and other rehabilitation services) have also been identified as challenges by patients and caregivers.<sup>5,55-57</sup>

A report from Ontario's Expert Group on Home and Community Care states that "family and caregivers need access to and funding of a core consistent 'basket of services' that recognizes nonclinical supports such as homemaking, meal preparation, supportive housing, transportation and respite."<sup>53</sup> Effectively being able to address these needs significantly increases the likelihood of a successful transition from hospital to home.<sup>5</sup>

People transitioning from hospital to home and their caregivers need accurate information about what services and medications they will need to pay for.<sup>53</sup> For those unable to pay for unfunded or partially funded community-based services, medications, or medical equipment and devices, support should be provided by health care professionals or a home and community care coordinator to ensure their care needs are met. Without this support, many patients will go without care.

## What This Quality Statement Means

### For Patients

Before you leave the hospital, a health care professional should:

- Let you know about any health or community support services you will need once you are home again
- Explain the services and medications that require you to pay all or part of the cost and options you can explore if you can't afford to pay for some services

## For Clinicians

Work together with your fellow health care providers (hospital providers, primary care and home and community care providers, home and community care coordinators, and/or social workers) to provide people transitioning from hospital to home and their caregivers with information regarding which health and community support services and medications are funded and which they will need to pay for. Provide information on, and help link patients to, health and community supports services, funded and not funded. Let patients and their caregivers know any out-of-pocket costs (when known) and assist with reviewing private insurance coverage or other funding sources, such as March of Dimes Canada, Non-Insured Health Benefits (NIHB) Program, Ontario Disabilities Support Program, Ontario Drug Benefit program, Ontario Works, and [thehealthline](#). Help those who will need assistance paying review private insurance coverage or find alternative sources of funding.

## For Health Services Planners

Ensure that systems, processes, and resources are in place for health care providers to work together to provide information and planning for health and community supports services and medications that are funded and not funded.

## QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

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- Percentage of people discharged from hospital to home whose ability to pay for out-of-pocket health care costs is assessed by their health care team
- Percentage of people discharged from hospital to home who report being provided with the information they need about available funding for health services that are not publicly funded
- Percentage of people discharged from hospital to home who report not receiving the help they needed because of the cost

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

# Appendices

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# Appendix 1. Recommendations for Adoption: How the Health Care System Can Support Implementation

While clinicians and organizations are working to provide the care outlined in the quality standard, further support is needed from the system to support the delivery of high-quality care on the front lines as people transition between hospital and home.

The following system-level barriers that affect implementation of this quality standard have been identified:

- Awareness, uptake, and integration of digital health solutions, electronic information-sharing systems, and clinical viewers is not consistent across the province, which may contribute to inefficient or less-than-ideal ways of sharing patient information (e.g., fax machines). There is an immediate need to develop, improve, and strengthen information-sharing among hospitals, primary care, and applicable home and community care providers (see the definition of “home and community care providers” in quality statement 1)
- Hospitals may not be aware of community mental health and addiction programs, wait times for community mental health and addiction services, and the availability of intensive services in the community. A quality standard focusing on transitions between inpatient mental health settings and home is in development
- Accuracy, timeliness, and completeness of discharge summaries (or transition plans) all require improvement, including increasing the involvement of patients and caregivers in transition planning
- Access to programs and services available in the community, including mental health, addiction, and rehabilitation supports, is limited and variable
- There is a shortage of personal support workers and other health care providers available to provide care at home; when home care is available, there are concerns about the quality of services provided

These barriers emerged from our review of the available evidence; a scan of existing programs; extensive consultation with the Transitions Between Hospital and Home Quality Standard Advisory Committee, stakeholders, and organizations; and input received when a draft of this quality standard was posted for public feedback.

## Equity Considerations

- Care that is not covered by the provincial insurance plan and limits to funded services disproportionately affect treatment after discharge and subsequent outcomes of those individuals living in poverty<sup>10</sup>
- Consistent access to affordable and effective medications can be challenging due to costs associated with filling a prescription and the patchwork system of public and private drug plans
- Lack of public transportation and limited access to medical specialists are common challenges faced by those living in rural areas
- Language barriers, as well as low health literacy, affect how well patients and caregivers understand the education, training, and support provided at discharge

Specific population groups face greater challenges during transitions between hospital and home.

For example:

- Children and adolescents have different needs than adults when transitioning between hospital and home, including children who are transitioning into adult services. It is also important to consider the unique needs of children in care; for example, child welfare may need to be involved in transition planning. Family members and caregivers require more education, training, and support from health care providers to ensure they feel confident in providing care for their own children at home
- Individuals living with an addiction or a mental health condition have identified coordination of follow-up care and access to mental health and addiction supports as higher priorities than have other population groups.<sup>10</sup> For children and adolescents living with an addiction or a mental health condition, there is an even greater need to ensure that mental health and addiction programs and services are available in the community. In addition, health care providers in hospitals require greater knowledge of existing mental health and addiction programs and of supports available in the community so that they can make appropriate referrals
- Individuals with experiences of trauma may have fewer supports in the community and may be more vulnerable to deteriorating physical and/or mental health. Health care providers should consider using trauma-informed practices

Specific adoption strategies should not reinforce current states of inequity and inequality faced by specific populations, such as language barriers, lack of access, and unique care needs.

Rather, they should contribute to improvement or highlight areas of opportunity.



## **A Note on 2019/20 Quality Improvement Plans**

Based on the [planned changes](#) to the Quality Improvement Plan program, three themes were selected to be priority areas and indicators for 2019/20. One theme is timely and efficient transitions. The following indicators in this quality standard align with the indicators in the 2019/20 Quality Improvement Plans:

- Discharge summaries sent from hospital to primary care providers within 48 hours of discharge
- Patient and caregiver received enough information when they left the hospital
- Medication reconciliation at discharge
- Unplanned emergency department visits within 30 days after hospital discharge

A number of resources have been developed to support the implementation of change ideas listed in the 2019/20 Quality Improvement Plans to support improved transitions in care.

Tools and resources that support implementation each of the quality statements will be posted on [Quorum](#), as will change ideas specific to the new Quality Improvement Plan indicators.

At the local level, the statements, related measures (Appendix 2), and implementation supports can help clinicians and organizations determine where there are opportunities to focus their improvement efforts.

## Recommendations for Adoption

The following are recommendations to bridge system-level gaps and address some of the barriers highlighted above.

Action may be required by Ontario Health, the Ministry of Health, the Ministry of Long-Term Care, or other health system partners to facilitate the adoption of this quality standard in everyday practice.

### Recommendation I

Strengthen and support transition planning with patients and caregivers by implementing and spreading the Patient Oriented Discharge Summary (PODS) and sharing the Going Home from the Hospital patient guide.

**Actors:** Hospitals, Ontario health teams, Ontario Health

**Time frame for implementation:** Immediate (initiate within 1–2 years)

### Recommendation II

Improve digital access to integrated health information to ensure that accurate, complete, and current information is accessible by patients, caregivers, and health care providers in all care settings. Consider:

- Updating and revising all relevant health information privacy policies, regulations, and legislation (e.g., *Personal Health Information Protection Act of 2004*) related to health information to improve access to and sharing of health information
- Partnering with patients, caregivers, and care providers to identify what information matters most to them and how they want to access it
- Prioritizing to increase access to integrated health information within Ontario health teams

**Actors:** Ministry of Health, Ministry of Long-Term Care, Ontario health teams

**Support:** Ontario Health (eHealth Ontario), OntarioMD

**Time frame for implementation:** Immediate (initiate within 1–2 years)

### Recommendation III

Using a health equity lens, develop processes that ensure that there is transparency with patients and caregivers regarding the type and amount of home care and community support services patients are eligible to receive.

**Actors:** Ontario Health, Ontario health teams

**Support:** Home and community care providers, Ministry of Health, Ministry of Long-Term Care

**Time frame for implementation:** Immediate (initiate within 1–2 years)

### Recommendation IV

Conduct a root-cause analysis at the local and regional levels to identify specific local and regional gaps in transitions between hospital and home, and ensure that the care delivered meets the care outlined in the quality standard

**Actors:** Ontario health teams, health care providers

**Support:** Ontario Health, Ministry of Health, Ministry of Long-Term Care

**Time frame for implementation:** Immediate (initiate within 1–2 years)

### Recommendation V

Use the results of the root-cause analysis to design and inform funding models to support transitions between hospital and home

**Actors:** Ontario health teams, health care providers

**Support:** Ontario Health, Ministry of Health, Ministry of Long-Term Care

**Time frame for implementation:** Medium-term (initiate within 2–3 years)

## Recommendation VI

Implement learning modules on patient and caregiver education in health care providers' curricula, as well as continuing professional development, residency, and credentialing programs, so that health care providers develop the knowledge and skills to better equip patients and caregivers with the information and support they need to seamlessly transition between hospital and home. Embed the film [Falling Through the Cracks: Greg's Story](#) into health care providers' learning curricula. This film illustrates many of the important themes contained in this quality standard.

Patient, family and caregiver education, training, and support should be guided by the values identified by the Minister's Patient and Family Advisory Council in the [Patient Declaration of Values for Ontario](#).

**Actors:** Educational institutions, accreditation programs, continuing education programs, colleges

**Support:** Health care organizations, Ontario health teams

**Time frame for implementation:** Immediate (initiate within 1–2 years)

# Appendix 2. Measurement to Support Improvement

The Transitions Between Hospital and Home Quality Standard Advisory Committee identified some overarching goals for this quality standard. These goals were mapped to indicators that can be used to monitor the progress being made to improve transitions from hospital to home in Ontario. Some indicators are provincially measurable, while one can be measured using only locally sourced data.

Collecting and using data associated with this quality standard is optional. However, data will help you assess the quality of care you are delivering and the effectiveness of your quality improvement efforts.

We realize this standard includes a lengthy list of indicators. We've given you this list so you don't have to create your own quality improvement indicators. We recommend you identify areas to focus on in the quality standard and then use one or more of the associated indicators to guide and evaluate your quality improvement efforts.

To assess equitable delivery of care, you can stratify locally measured indicators by patient socioeconomic and demographic characteristics, such as age, education, gender, income, language, and sex.

Our [measurement guide](#) for transitions between hospital and home provides more information and concrete steps on how to incorporate measurement into your planning and quality improvement work.

## How to Measure Overall Success

### Indicators That Can Be Measured Using Provincial Data

**Percentage of people discharged from hospital to home who report feeling that they were involved in decisions about their care and treatment as much as they wanted to be**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report feeling that they were involved in decisions about their care and treatment as much as they wanted to be
- Data source: Canadian Patient Experiences Reporting System, Canadian Institute for Health Information

**Percentage of people discharged from hospital to home who report that the doctors or staff where they usually get medical care seem informed and up to date about the care they received in hospital**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report that the doctors or staff where they usually get medical care seem informed and up to date about the care they received in hospital
- Data source: Health Care Experiences Survey, Ministry of Health

**Percentage of people discharged from hospital to home who received home care and community support services who report that their home care started when they needed it**

- Denominator: total number of people discharged from hospital to home who received home care
- Numerator: number of people in the denominator who report that their home care started when they needed it
- Data sources: New Client and Caregiver Experience Evaluation Survey (in development), local health integration networks

**Median and mean wait times from hospital discharge to first home care service date for people newly approved for home care services**

- Data source: Home Care Database, Ministry of Health

**Percentage of people discharged from hospital to home whose primary informal caregiver reports feeling prepared for the role of caregiving (measurable for caregivers of home care clients only)**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator whose primary informal caregiver reports feeling prepared for the role of caregiving
- Data source: New Client and Caregiver Experience Evaluation Survey (in development), local health integration networks

### **Percentage of people discharged from hospital to home who visit the emergency department within (1) 7 days after discharge and (2) 30 days after discharge**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who visit the emergency department within (1) 7 days after discharge and (2) 30 days after discharge
- Data sources: National Ambulatory Care Reporting System and Discharge Abstract Database, Canadian Institute for Health Information

### **Percentage of people discharged from hospital to home who are readmitted to hospital within (1) 7 days after discharge and (2) 30 days after discharge**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who are readmitted to hospital within (1) 7 days after discharge and (2) 30 days after discharge
- Data source: Discharge Abstract Database, Canadian Institute for Health Information

### **Indicators That Can Be Measured Using Only Local Data**

#### **Percentage of people discharged from hospital to home whose discharge summaries are delivered to primary care providers within 48 hours after discharge from hospital**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator whose discharge summaries are delivered to primary care providers within 48 hours after discharge from hospital
- Data source: local data collection
- Note: This indicator is included in the 2019/20 Hospital Quality Improvement Plans

### **How to Measure Improvement for Specific Statements**

#### **Quality Statement 1: Information-Sharing on Admission**

**Percentage of people discharged from hospital whose hospital notified their primary care and home and community care providers and relevant specialist physicians about the hospitalization soon after admission**

- Denominator: total number of people discharged from hospital
- Numerator: number of people in the denominator whose hospital notified their primary care and existing specialist physicians and home and community care providers about the hospitalization soon after admission
- Data source: local data collection

**Local availability of integrated electronic health records that allow hospital teams and primary care and home and community care providers and relevant specialist physicians to share information with each other**

- Data source: local data collection

**Quality Statement 2: Comprehensive Assessment**

**Percentage of people discharged from hospital to home whose comprehensive assessment was updated regularly throughout their hospital stay**

- Denominator: total number of people discharged from hospital to home who had a comprehensive assessment
- Numerator: number of people in the denominator whose comprehensive assessment was updated regularly throughout their hospital stay
- Data source: local data collection

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

**Percentage of people discharged from hospital to home who report feeling that they were involved in decisions about their transition planning as much as they wanted to be**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report feeling that they were involved in decisions about their transition planning as much as they wanted to be
- Data source: local data collection via patient survey



**Percentage of people discharged from hospital to home who report feeling that their family and caregivers were involved in decisions about their transition planning as much as they wanted to be**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report feeling that their family or caregivers were involved in decisions about their transition planning as much as they wanted to be
- Data source: local data collection via patient/caregiver survey

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

**Percentage of people discharged from hospital to home (and their caregivers) who report having received enough information about what to do if they were worried about their health condition or treatment after leaving the hospital**

- Denominator: total number of people discharged from hospital to home (and their caregivers)
- Numerator: number of people in the denominator who reported that they received enough information about what to do if they were worried about their health condition or treatment after leaving the hospital
- Data source: local data collection via patient survey
- Note: A validated survey question that can be used to inform local data collection is available in the Canadian Patient Experiences Survey<sup>58</sup>: “Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?” (Response options: “Not at all, Partly, Quite a bit, Completely”)

**Percentage of people discharged from hospital to home who report feeling they have the support and services they need to help them manage their health condition at home**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report feeling they have the support and services they need to help them manage their health condition at home
- Data source: local data collection via patient survey
- Note: A validated survey question that can be used to inform local data collection is available in the Commonwealth Fund International Health Policy Survey<sup>59</sup>: “After you left the hospital, did you feel that you had the support and services you needed to help you manage your health condition at home?” (Response options: “Yes, No, I did not need support to manage my health, Not sure, Decline to answer”)

### **Percentage of people discharged from hospital to home who report knowing whom to contact if they have a question about their health condition or treatment**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report knowing whom to contact if they have a question about their health condition or treatment
- Data source: local data collection via patient survey
- Note: A validated survey question that can be used to inform local data collection is available in the New Client and Caregiver Experience Evaluation Survey (in development)<sup>60</sup>: “When you left the hospital, did you know whom to contact if you had a question about your condition or treatment?” (Response options: “Yes, No, Do not know/do not remember”)

### **Percentage of people discharged from hospital to home whose primary informal caregiver reports feeling prepared for the role of caregiving (measurable for caregivers of home care clients only)**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator whose primary informal caregiver reports feeling prepared for the role of caregiving
- Data source: New Client and Caregiver Experience Evaluation Survey (in development), local health integration networks
- Note: This indicator is also included in the section “How to Measure Overall Success”

### **Quality Statement 5: Transition Plans**

#### **Percentage of people discharged from hospital to home who were given a written transition plan before leaving hospital**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who were given a written transition plan before leaving hospital
- Data source: local data collection
- Note: A validated survey question that can be used to inform local data collection is available in the Commonwealth Fund International Health Policy Survey<sup>59</sup>: “When you left the hospital, did you receive written information on what to do when you returned home and what symptoms to watch for?” (Response options: “Yes, No, Not sure, Decline to answer”)

**Percentage of people discharged from hospital to home whose discharge summaries are delivered to primary care providers within 48 hours after discharge from hospital**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator whose discharge summaries are delivered to primary care providers within 48 hours after discharge from hospital
- Data source: local data collection
- Note: This indicator is included in the 2019/20 Hospital Quality Improvement Plans
- Note: This indicator is also included in the section “How to Measure Overall Success”

**Percentage of people discharged from hospital to home who receive home and community care, whose discharge summaries are sent to their home and community care providers within 48 hours after discharge**

- Denominator: total number of people discharged from hospital to home who receive home and community care
- Numerator: number of people in the denominator whose discharge summaries are sent to their home and community care providers within 48 hours after discharge
- Data source: local data collection

**Percentage of people discharged from hospital to home who report that the doctors or staff where they usually get medical care seem informed and up to date about the care they received in hospital**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report that the doctors or staff where they usually get medical care seem informed and up to date about the care they received in hospital
- Data source: Health Care Experiences Survey, Ministry of Health

**Local availability of integrated electronic health records that allow hospital teams and home and community care providers to share information with each other**

- Data source: local data collection

### **Quality Statement 6: Coordinated Transitions**

#### **Percentage of people discharged from hospital to home who had a named community-based health care professional responsible for their care coordination at the time of discharge**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who had a named community-based health care professional responsible for their care coordination at the time of discharge
- Data source: local data collection

#### **Percentage of people in hospital preparing for discharge (or their caregivers) who report they know who is primarily responsible for coordinating their discharge**

- Denominator: total number of people in hospital preparing for discharge (or their caregivers)
- Numerator: number of people in the denominator who report they know who is primarily responsible for coordinating their discharge
- Data source: local data collection via patient survey

#### **Percentage of people discharged from hospital to home (or their caregivers) who report being unable to contact their health care professional when they needed to**

- Denominator: total number of people discharged from hospital to home (or their caregivers) who attempted to contact their health care professional
- Numerator: number of people in the denominator who report being unable to contact their health care professional
- Data source: local data collection via patient survey

#### **Local availability of hospital systems that provide patients, families, caregivers, and home and community care providers a named contact responsible for timely transition planning, coordination, and communication**

- Data source: local data collection

### **Quality Statement 7: Medication Review and Support**

#### **Percentage of people discharged from hospital to home whose medications were reconciled at discharge**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator whose medications were reconciled at discharge
- Data source: local data collection
- Note: This indicator is included in the 2019/20 Hospital Quality Improvement Plans

#### **Percentage of people discharged from hospital to home who have a drug-related emergency department visit or hospital readmission within 30 days after discharge**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who have a drug-related:
  - Emergency department visit within 30 days after discharge *or*
  - Hospital readmission within 30 days after discharge
- Data sources: Canadian Institute for Health Information's National Ambulatory Care Reporting System and Discharge Abstract Database

#### **Percentage of people discharged from hospital to home (or their caregivers) who report having a clear understanding of their prescribed medications**

- Denominator: total number of people discharged from hospital to home (or their caregivers)
- Numerator: number of people in the denominator who report having a clear understanding of their prescribed medications
- Data source: local data collection via patient survey
- Note: A similar survey question can be found in the Canadian Patient Experiences Survey<sup>58</sup>: "Before you left the hospital, did you have a clear understanding about all of your prescribed medications, including those you were taking before your hospital stay?" (Response options: "Not at all, Partly, Quite a bit, Completely, Not applicable")
- Exclusions: Those not taking any prescribed medications

**Local availability of hospital systems that provide discharge medication lists and clinical indications to community-based pharmacies upon discharge, including a full list of medications and follow-up appointments**

- Data source: local data collection

**Quality Statement 8: Coordinated Follow-Up Medical Care**

**Percentage of people discharged from hospital to home who had follow-up medical care appointments coordinated and booked with their primary care provider (or most responsible provider) and/or medical specialist before discharge**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who had follow-up medical care appointments coordinated and booked with their primary care provider (or most responsible provider) and/or medical specialist before discharge
- Data source: local data collection
- Note: A validated survey question that can be used to inform local data collection is available in the Commonwealth Fund International Health Policy Survey<sup>59</sup>: “When you left the hospital, did the hospital make arrangements or make sure you had follow-up care with a doctor or other health care professional?” (Response options: “Yes, No, Not applicable/did not need follow up care, Not sure, Decline to answer”)

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

**Median and mean wait times from hospital discharge to first home care service date for people newly approved for home care services**

- Population: people discharged from hospital to home with new home care services arranged (excluding case management services)
- Potential stratification: home care service type
- Data source: Home Care Database, Ministry of Health
- Note: This indicator is also included in the section “How to Measure Overall Success”

### **Percentage of people discharged from hospital to home who are referred for home care and community support services and who report receiving enough hours of home care services**

- Denominator: total number of people discharged from hospital to home who are referred for home care and community support services
- Numerator: number of people in the denominator who report receiving enough hours of home care services
- Data source: local data collection via patient survey
- Note: A validated survey question that can be used to inform local data collection is available in the New Client and Caregiver Experience Evaluation Survey (in development)<sup>60</sup>: “Do you receive enough hours of home care?” (Response options: “I receive more than enough, I receive enough, I need a little more, I need a lot more, Do not know/do not remember”)
- Exclusion: people who reply “Do not know/do not remember”

### **Percentage of people discharged from hospital to home who received home care and community support services who report that their home care started when they needed it**

- Denominator: total number of people discharged from hospital to home who received home care and community support services
- Numerator: number of people in the denominator who report that their home care started when they needed it
- Data source: local data collection via patient survey
- Note: A validated survey question that can be used to inform local data collection is available in the New Client and Caregiver Experience Evaluation Survey (in development)<sup>60</sup>: “Would you agree that your home care started when you needed it?” (Response options: “Yes, No, Do not know/do not remember”)
- Exclusion: people who reply “Do not know/do not remember”
- Note: This indicator is also included in the section “How to Measure Overall Success”

### **Quality Statement 10: Out-of-Pocket Costs and Limits of Funded Services**

#### **Percentage of people discharged from hospital to home whose ability to pay for out-of-pocket health care costs is assessed by their health care team**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator whose ability to pay for out-of-pocket health care costs is assessed by their health care team
- Data source: local data collection

#### **Percentage of people discharged from hospital to home who report being provided with the information they need about available funding for health services that are not publicly funded**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report being provided with the information they need about available funding for health services that are not publicly funded
- Data source: local data collection via patient survey

#### **Percentage of people discharged from hospital to home who report not receiving the help they needed because of the cost**

- Denominator: total number of people discharged from hospital to home
- Numerator: number of people in the denominator who report not receiving the help they needed because of the cost
- Data source: local data collection via patient survey
- Note: An example of a validated survey question that can be used to inform your local data collection is available in the Commonwealth Fund International Health Policy Survey<sup>59</sup>:  
“In the past year, was there a time you did NOT receive the help you needed because of the cost?”  
(Response options: “Yes, No, Not sure, Decline to answer”)



## Appendix 3. Glossary

**Caregiver:** A person who provides care and support in a nonprofessional capacity. Caregivers may be family members, friends, or anyone else identified by the person transitioning between hospital and home. This role may be carried out by one or more people and may include direct care provision, emotional support, care coordination, advocacy, and financial help.<sup>61</sup> Other terms commonly used to describe this role include “care partner,” “carer,” “family caregiver,” “informal caregiver,” and “primary caregiver.”

**Circle of care:** “Those members of a health care team who are included in an individual’s implied consent to collect, use, and disclose a patient’s/client’s personal health information for the purpose of providing health care in specific circumstances,”<sup>34</sup> as defined in Ontario’s privacy law, the *Personal Health Information Protection Act* of 2004. This may also include family members and caregivers whom the patient consents to include in their circle of care, and any substitute decision-makers appointed under a “Power of Attorney for Personal Care.”

**Family:** Family members, friends, or supportive people not necessarily related to the person transitioning between hospital and home. This person defines their family and who will be involved in their care.

**Health care professionals:** Regulated professionals, such as nurses, nurse practitioners, occupational therapists, pharmacists, physicians (family doctors, specialists), physiotherapists, psychologists, respiratory therapists, social workers, and speech-language pathologists.

**Health care providers:** Regulated professionals and also people in unregulated professions, such as administrative staff, behavioural support workers, personal support workers, recreational staff, spiritual care staff, and volunteers.

**Home:** A person’s usual place of residence.

**Hospital team:** All health care providers responsible for providing coordinated care for a person from hospital admission through their transition home. This includes, but is not limited to:

- Dietitians
- Mental health and addiction services providers
- Nurses and nurse practitioners
- Occupational therapists
- Pharmacists
- Physicians
- Physiotherapists
- Psychologists
- Respiratory therapists
- Social workers
- Speech-language pathologists
- Volunteers

**Primary care provider:** A family physician (also called a primary care physician) or nurse practitioner.

# Appendix 4. What We've Heard From Patients and Caregivers

In consulting with patients and caregivers across the province, we learned:

1. There are not enough publicly funded home care services to meet the need
2. Home care support is not in place when patients arrive home from hospital
3. Patients have to advocate to get enough home care
4. Patients are not being involved in discharge planning
5. Once home, patients do not have contact numbers for people to call if there is a problem
6. During discharge planning, hospital providers assume family and friends will provide care
7. There are long waits for follow-up appointments with family doctors and specialists
8. Patients receive unclear or inconsistent communication about their health status

## How We Consulted With Patients and Caregivers

Improving patient and caregiver experiences during transitions between hospital and home is a priority for Ontario's health system, but little research exists on what matters most to them. Therefore, to support the development of this quality standard, our organization partnered with health care and community organizations to conduct a province-wide consultation in 2018 through broad engagement with people with lived experience of transitions from hospital to home. We spoke with people who had been discharged home after an overnight admission in an Ontario hospital within the past 3 years; we also spoke with caregivers of people who had been hospitalized and discharged home. We asked them about the factors that affected their experiences when transitioning from hospital to home,<sup>5</sup> and we defined "home" as including long-term care, supportive housing, and shelters, in addition to personal residences.

A total of 665 people completed our online survey; 40% had been patients, 53% had been caregivers, and 7% had been both patients and caregivers. In addition, 71 people participated in one of eight group discussions. We heard from a diverse group of patients and caregivers in Ontario with lived experience of a transition from hospital to home.<sup>5</sup> Most (95%) reported being discharged to an apartment, house, or other community residence, while 5% were discharged to a long-term care home and 8% were discharged to a rehabilitation facility or chronic care hospital.

Researchers grouped input from participants in the survey and discussion groups into 52 unique concepts related to the transition process. These concepts covered the continuum of care from being in hospital to preparing for a successful discharge (i.e., discharge planning and process, timely services, and logistical support after discharge) and returning to the community (i.e., coordination of follow-up medical care, home care, community-based rehabilitation and medical care in the community, out-of-pocket costs, and the limitations of funded services). People most often reported challenges with home care in terms of the consistency, reliability, sufficiency, and timeliness of publicly funded services. Many relied on family, friends, private services, or charities to fill the gaps. The second most common theme was related to challenges with the discharge process, including such factors as insufficient communication, a lack of patient and caregiver involvement in the process, and timing.

In a second phase of this research, a smaller number of participants answered two key questions:

1. Which issue would lower your confidence to care for yourself (for patients) or the patient (for caregivers)?
2. Which areas should be prioritized for improvement (as top priorities for the health system)?

The eight concepts listed above were rated most important for both questions; they are listed in order of priority to respondents. The top-rated concepts were fairly consistent across subgroups of patients and caregivers from different backgrounds and circumstances.

Our engagement with people who have experienced transitions from hospital to home informed the development of this quality standard. Learning about people's experiences helped us to know what topics we needed to address.

# Acknowledgements

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