Health Links Leadership Community of Practice

Oct 14, 2016

Innovative Practices: Transitions Between Hospital and Home – Part 1

Today's Agenda

- Overview of Innovative Practices *and* Evidence-Informed Best Practices for *Transitions Between Hospital to Home*
- Deep dive into 3 Innovative Practices, guest speakers and patient stories
- Discussion: Implementing Innovative Practices in your Health Link
- Upcoming Events
- Polling

Webinar Learning Objectives

- Gain an understanding and learn more about the Innovative Practices and Evidence-Informed Best Practices for *Transitions Between Hospital and Home*
- Listen to and reflect on a patient story
- Collaborate with your colleagues and hear about how these practices may be implemented in your Health Links
- Understand the purpose and approach to measuring the impact of the practices

PARTICIPATING IN THE WEBINAR

- This webinar is being *recorded*.
- ALL participants will be muted (to reduce background noise). You can access your webinar options via the orange arrow button.
- Discussion period post presentation, please type your questions for the presenter after each presentation.
- If you would like to submit a question or comment at any time, please use Question box feature.

WEBINAR PANEL

Susan Taylor, *Director, Quality Improvement Program Delivery, Health Quality Ontario*

Caroline Buonocore, *Quality Improvement Specialist, Health Quality Ontario*

Monique LeBrun *Quality Improvement Specialist, Health Quality Ontario (Moderating Discussion)*

GUEST SPEAKERS

Mary Eastwood, *Director of the Don Valley Greenwood Health Link (DVGHL) and Interim Director of the Mid East Toronto Health Link (METHL)*

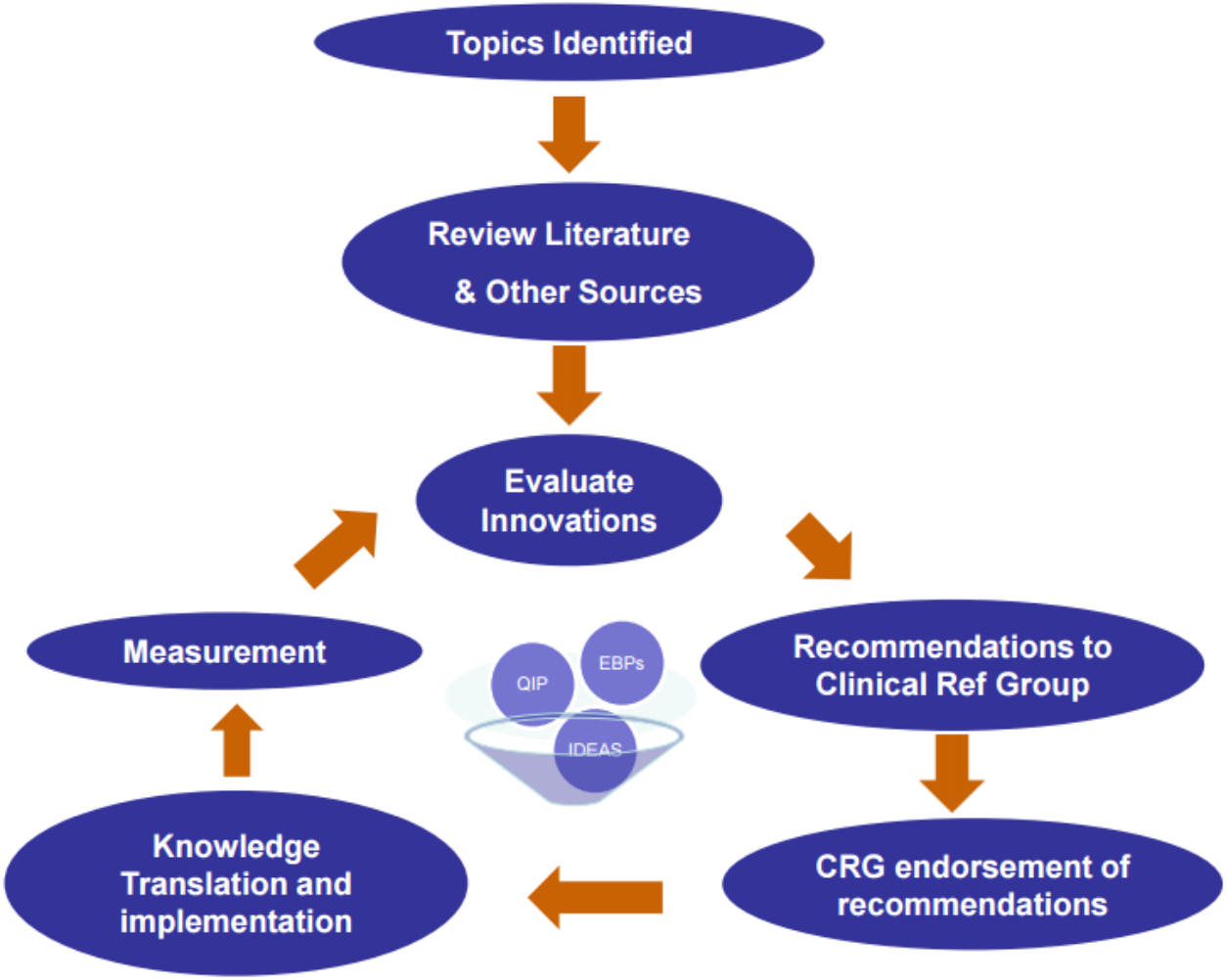
Jennifer Stewart, *Transition to Home Coordinator, Collingwood General Marine Hospital, with the South Georgian Bay Health Link*

Lisa Vogel, *Health Links Navigator, Georgian Bay Family Health Team, with the South Georgian Bay Health Link*

HEALTH LINKS LEADERSHIP COMMUNITY OF PRACTICE

'Communities of practice can be defined as groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly'

INNOVATIVE PRACTICES

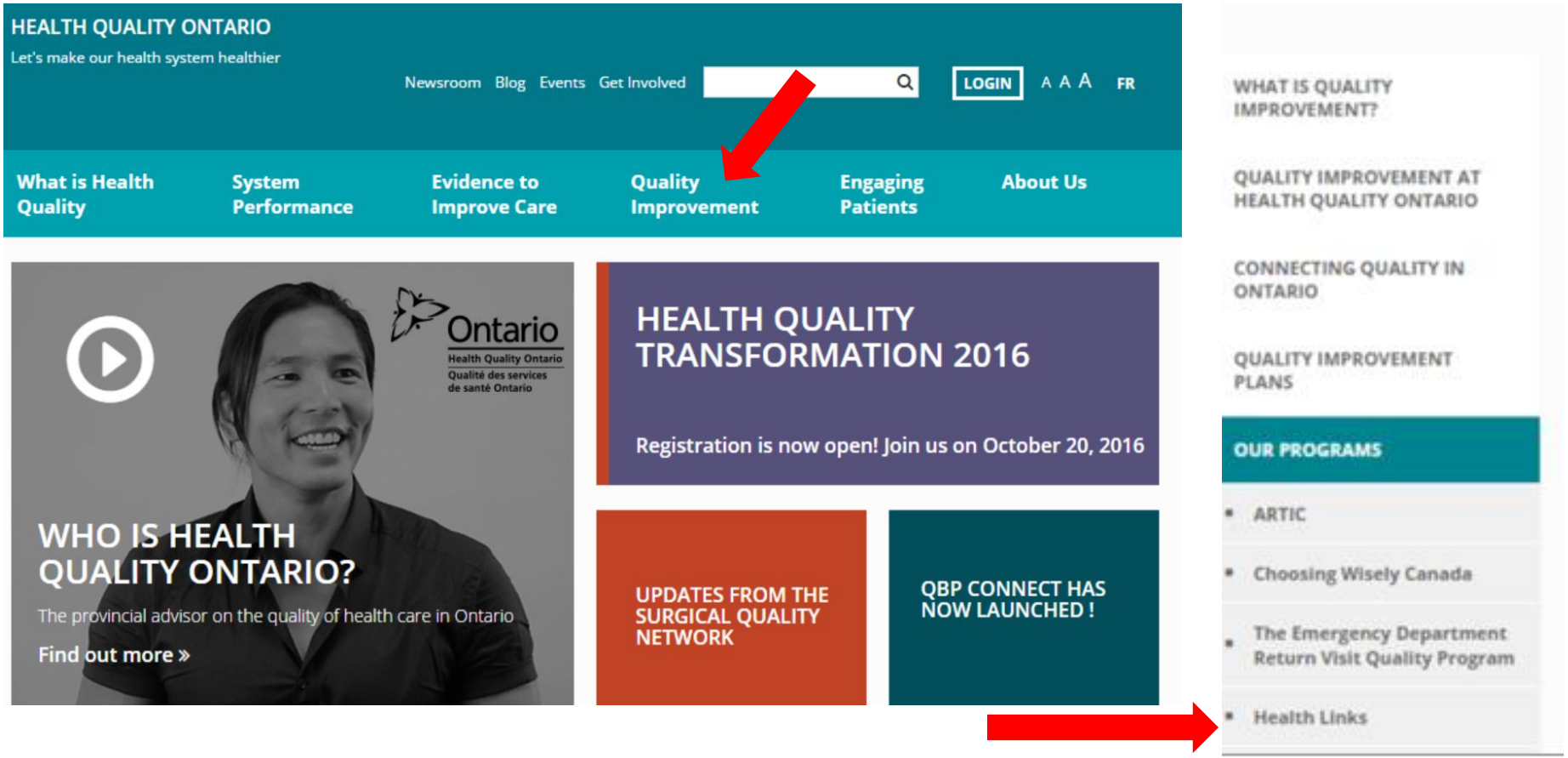


Transitions Between Hospital and Home

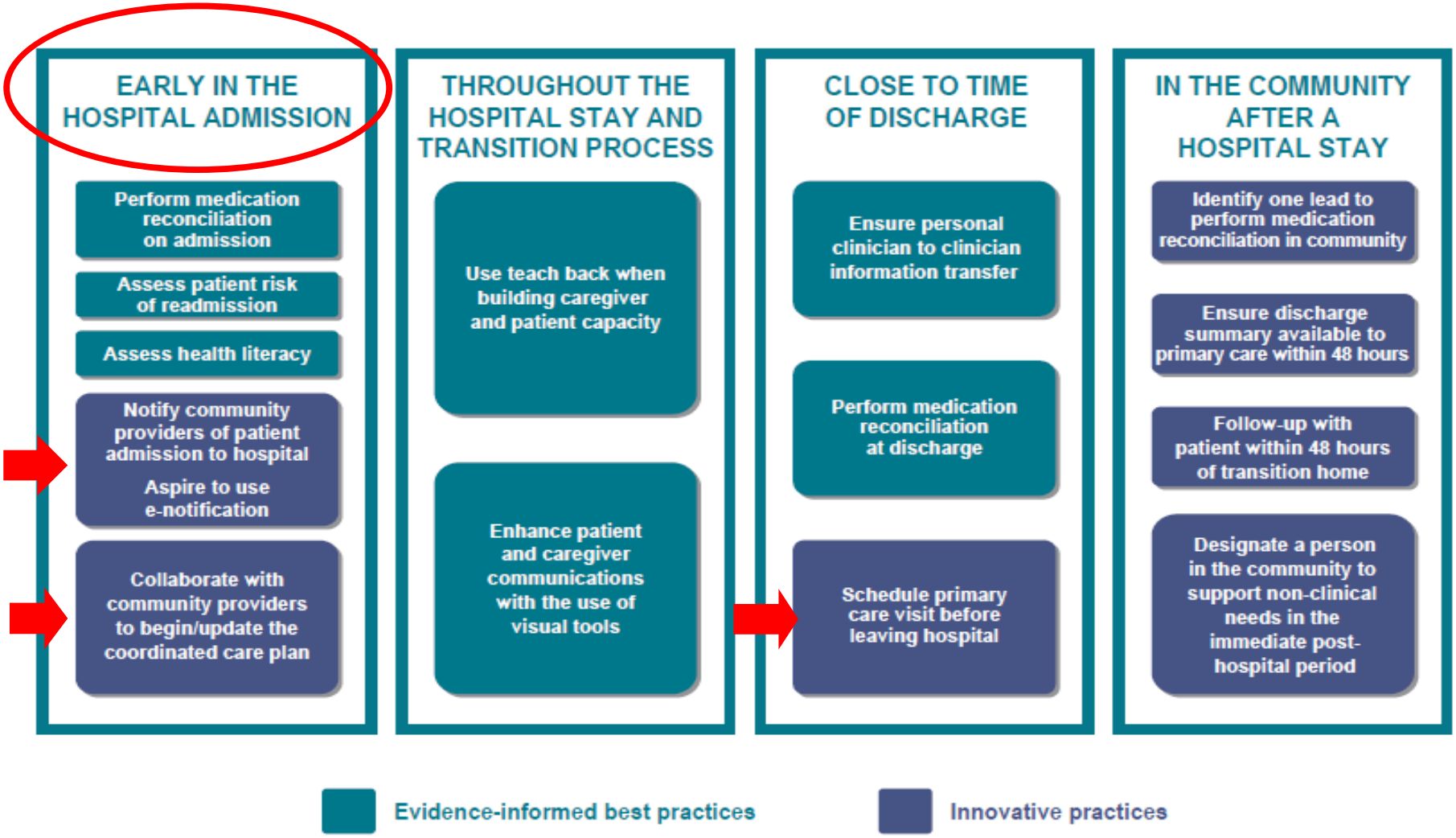
An important part of providing coordinated care to patients is improving patient transitions within the system to help ensure patients receive more responsive care that addresses their specific needs.

OVERVIEW OF PRACTICES FOR TRANSITIONS BETWEEN HOSPITAL & HOME

On Our Website www.hqontario.ca



Transitions between Hospital to Home



Evidence-Informed Best Practices

Steps for Transitions between Hospital and Home	Evidence-Informed Best Practice (cited in Quality Compass*)
Early in the Hospital Admission	Perform medication reconciliation on admission
	Assess patient risk of readmission
	Assess health literacy
Throughout the Hospital Stay and Transition Process	Use teach back when building caregiver and patient capacity
	Enhance patient and caregiver communications with the use of visual tools
Close to the Time of Discharge	Ensure personal clinician to clinician transfer
	Perform medication reconciliation at discharge

Summary of Innovative Practices

Steps for Transitions between Hospital and Home	Innovative Practice	Innovative Practice Assessment
Early in the Hospital Admission	Notify community providers of patient admission to hospital Aspire to use e-Notification	PROMISING
	Collaborate in hospital with community providers to begin/update the coordinated care plan	EMERGING
Close to the Time of Discharge	Schedule primary care visit before leaving hospital	PROMISING
In the Community After A Hospital Stay	Identify one lead to perform medication reconciliation in the community	PROMISING
	Ensure discharge summary available to primary care within 48 hours of discharge	PROMISING
	Follow-up with patient within 48 hours of transition home	EMERGING
	Designate a person in the community to support non-clinical needs in the immediate post-hospital period.	EMERGING

Transitions between Hospital and Home

Resources at a Glance

Ontario

Transitions Between Hospital and Home

Early in the Hospital Admission:
Notify Community Providers of Patient Admission to Hospital
Aspire to Use e-Notification

Released September 2016

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

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

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

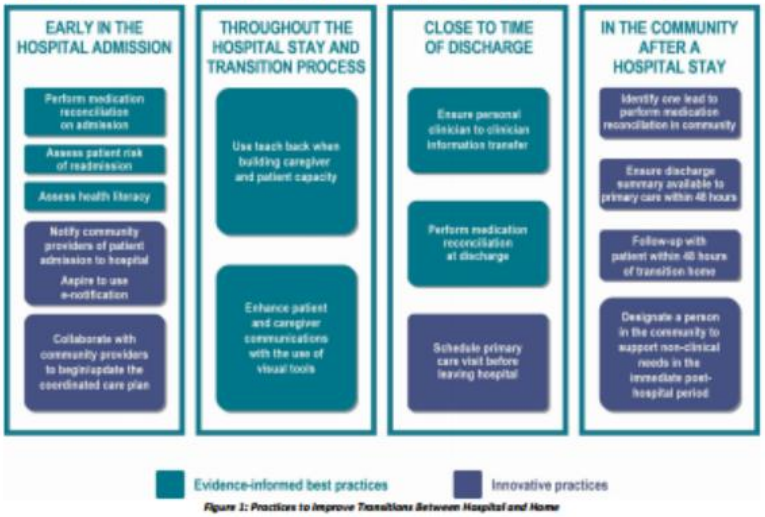


Figure 1: Practices to Improve Transitions Between Hospital and Home

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

1

Description of this Innovative Practice

The need for timely communication among care providers is well established in the literature. Interdisciplinary collaboration and communication support positive patient outcomes. Involving the circle of care early in the process allows more time to develop post-hospital treatment plans and helps patients and caregivers prepare for the shift from hospital to home, and involves:

a) Timely notification of a patient's hospital admission to the patient's community health care team provides them with an opportunity to make informed decisions about appropriate follow-up care based on the latest information. There are many ways that community providers can be contacted or notified. Recognizing that Health Links and the partner organizations vary, LHINs and Health Links are encouraged to adapt a system or process that meets their local context and population's needs.

b) E-notification is a real-time (or near real-time) electronic-message that notifies providers when their patients are discharged from the Emergency Department, or are admitted/discharged from in-patient units. E-notifications provide early access to the latest information about patients, and support the recommended guideline of patient follow-up within seven days post-discharge.

Innovative Practice	Innovative Practice Assessment[1]	Clinical Reference Group Endorsement for Spread
a) Notify community providers of patient admission to hospital b) Aspire to use e-Notification	PROMISING	a) Provincial spread with reassessment using the Innovative Practices Evaluation Framework[1] in one year (Sept 2017). b) Targeted spread with specific contexts (where e-notification is available or feasible)

Implementation of the Innovative Practice

Steps for Implementation	Tools and Resources	Considerations
1. Identify the patient Health Link care team identifies that a patient with multiple conditions and complex needs is transitioning to hospital (possibly in the ED or upon inpatient admission). ***2. Identify the circle of care*** The patient (or delegate) and the single point of contact identify the patient's existing circle of care members to be notified of the admission, including family physician/Nurse Practitioner, community care/service providers. ***3. Notify providers*** Once the circle of care members are identified, begin notifying them of the patient's admission.	Refer to the **Coordinated Care Management Innovative Practices** "Decision Support Tool" to identify new or existing Health Links patients (http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links/Coordinated-Care-Management/Identify-Patient). Example Health Links known to use e-notifications are: 1. **Toronto Central (TC) LHIN: Mid-West Health Link and University Health Network (UHN) with Toronto Community Addiction Team (TCAT)**	• E-notification methods may be dependent on organizations/providers' abilities to build on existing processes, partnerships and technologies. • E-notification systems may have their own onboarding phases planned, with Health Service Providers wait listed to receive access to the technology solution. • During the implementation of this innovation: o Consider using a single consent process and/or form (see **Coordinated Care Management Innovative Practice for Single Consent:**

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

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

2

Transitions Between Hospital to Home Tools and Resources

1. Summary o**f** **Evidence-Informed Best Practices** for Transitions Between Hospital to Home
2. Summary o**f** **Innovative Practices** for Transitions Between Hospital to Home and a detailed summary document ***per*** innovative practice which includes details:
   - Innovative Practice and Clinical Reference Group Recommendation
   - Implementation steps and links to Tools and Resources
   - Appended: Tools to support implementation of the practice, as indicated
   - Appended: Measurement Specifications and Data Collection suggestions.

Innovative Practices for Transitions Between Hospital to Home

DEEPER DIVE

Click

Ontario

Transitions Between Hospital and Home

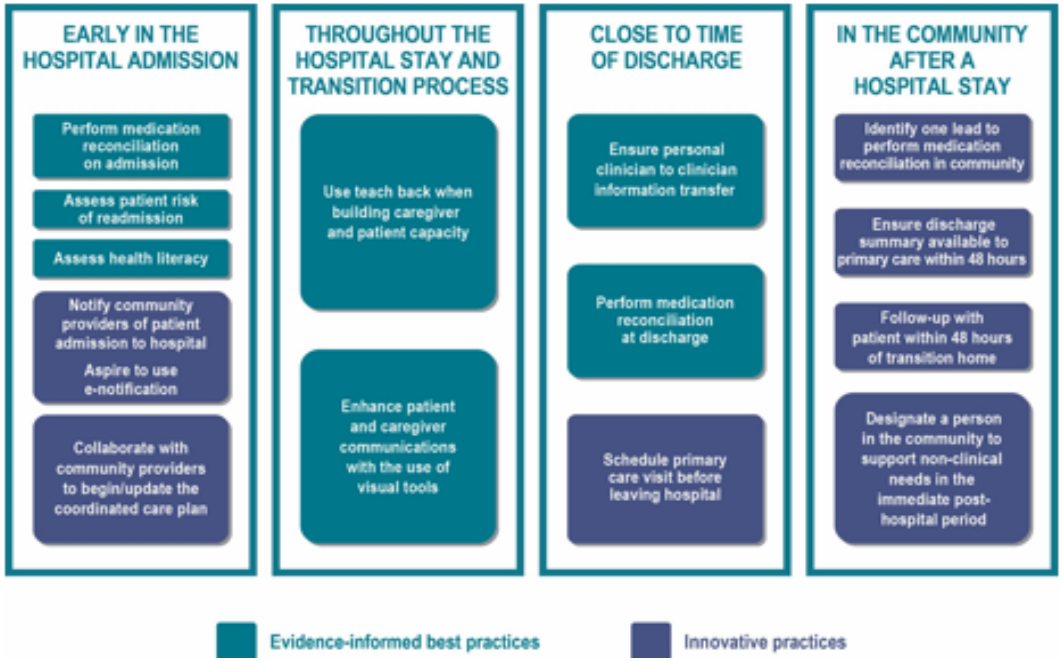
Early in the Hospital Admission: Collaborate in Hospital with Community Providers to Begin/Update the Coordinated Care Plan

Released September 2016

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

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

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



Ontario
Health Quality Ontario

Suggested Steps & Measures

Notify community providers of patient admission to hospital

Aspire to use e-notification

Identify the patient

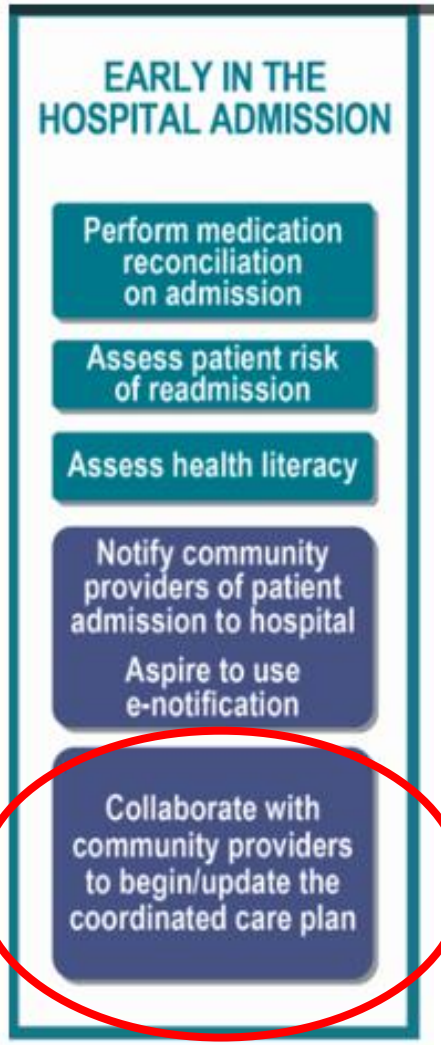
Identify the circle of care

Notify providers

e-notification

Suggested Outcome Measures	Suggested Process Measures
Percentage of patients with multiple conditions and complex needs who experienced an unplanned readmission to hospital within thirty (30) days of discharge.*	Percentage of patient admission notifications or e-notifications sent to primary care providers (PCP). Percentage of patients with multiple conditions and complex needs identified as needing connection to local Health Link on admission to hospital and offered this connection.

Click



Ontario

Transitions Between Hospital and Home

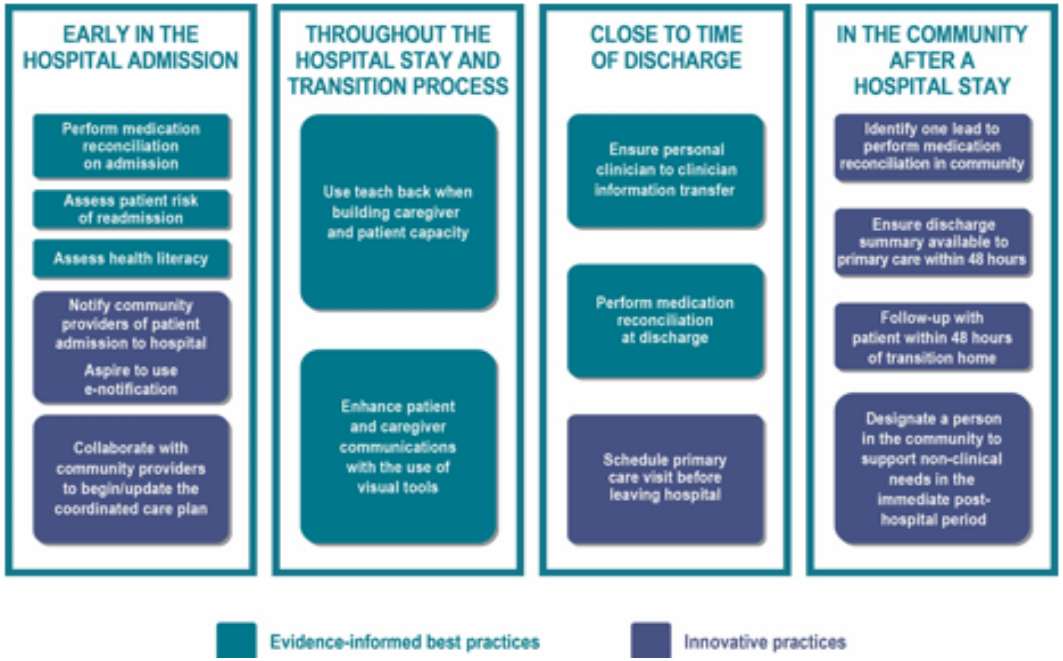
Early in the Hospital Admission: Collaborate in Hospital with Community Providers to Begin/Update the Coordinated Care Plan

Released September 2016

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

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

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



Ontario
Health Quality Ontario

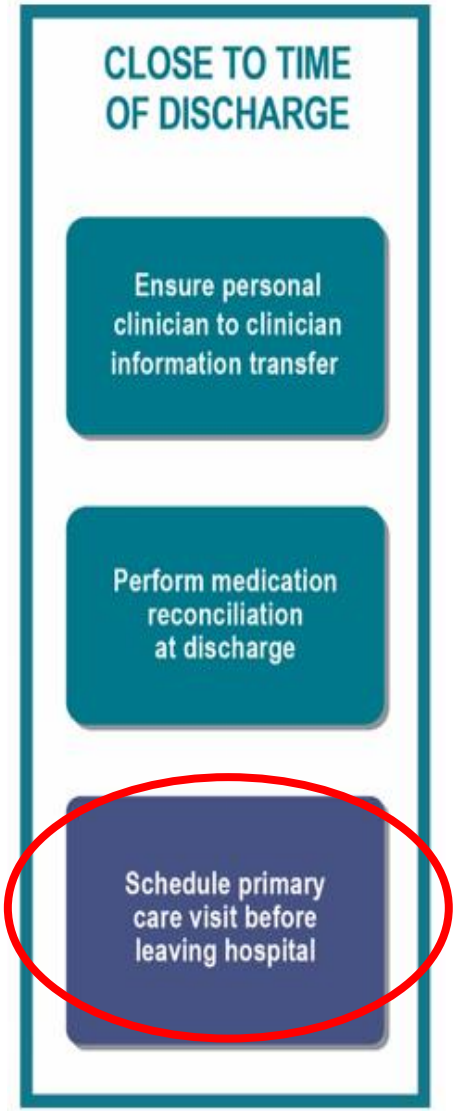
Suggested Steps & Measures

Identify and engage patient at admission

Leverage existing processes

Suggested Outcome Measures	Suggested Process Measures
Number of coordinated care plans developed or updated at least once with the patient during hospital admission	Percentage of single points of contact (identified prior to hospitalization) that collaborated on updates to the coordinated care plan while patient is in hospital Percentage of patients with multiple conditions and complex needs involved in developing and/or updating their coordinated care plan while in hospital

Click



Ontario

Transitions Between Hospital and Home

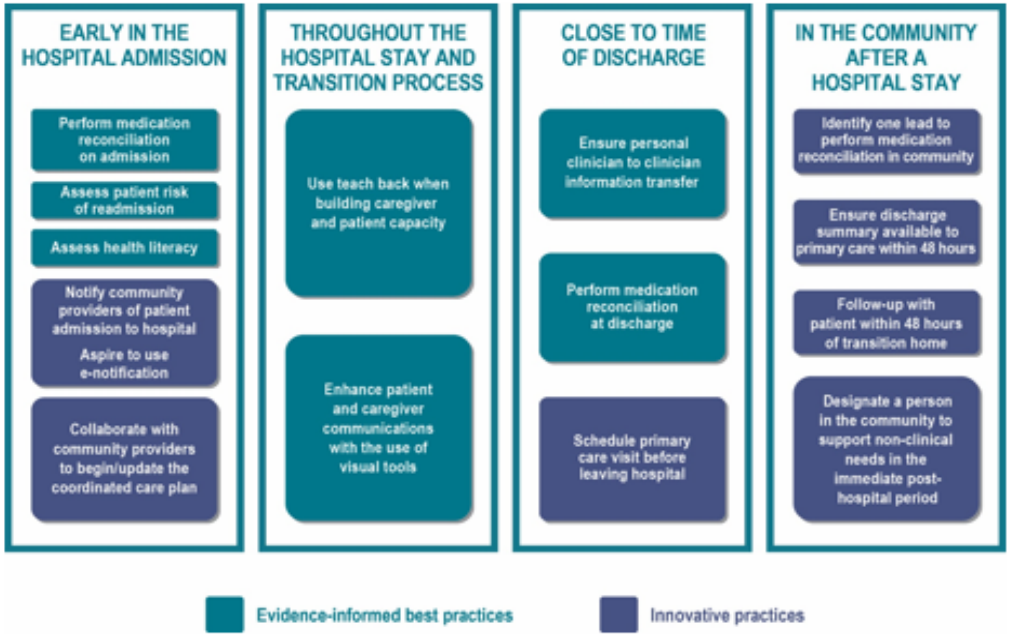
Close to Time of Discharge: Schedule a Primary Care Visit Before Leaving Hospital

Released September 2016

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

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

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



Ontario Health Quality Ontario

Suggested Steps & Measures

Obtain estimated date of discharge

Consult with patient for booking preference

Identify and mitigate barriers that would prevent the patient from attending the appointment

Book follow-up appointment with primary care to occur within seven days of discharge

Confirm follow-up appointment with patient

Document appointment in both the discharge plan and the Coordinated Care Plan

Ensure the primary care provider receives the discharge summary within 48 hours

Suggested Outcome Measures	Suggested Process Measures
Percentage of patients who have multiple conditions and complex needs who see their primary care provider within seven days (7) after discharge from hospital*	Percentage (%) of patients with multiple conditions and complex needs who have a primary care provider appointment that was **pre-booked** prior to leaving the hospital
Percentage of patients with multiple conditions and complex needs who experienced an unplanned readmission to hospital within thirty (30) days of discharge*	% of patients with multiple conditions and complex needs **identified as no-shows** to their follow-up appointment with their primary care provider appointment that was pre-booked to occur within seven (7) days post hospital discharge
	% of patients with multiple conditions and complex needs who are **unable to have an appointment pre-booked** within seven (7) days post discharge due to primary care availability
	% of patients with multiple conditions and complex needs who **decline** an offer for an appointment within seven (7) days of discharge
	Average **number of days to primary care follow-up** appointment for patients who have multiple conditions and complex needs post discharge

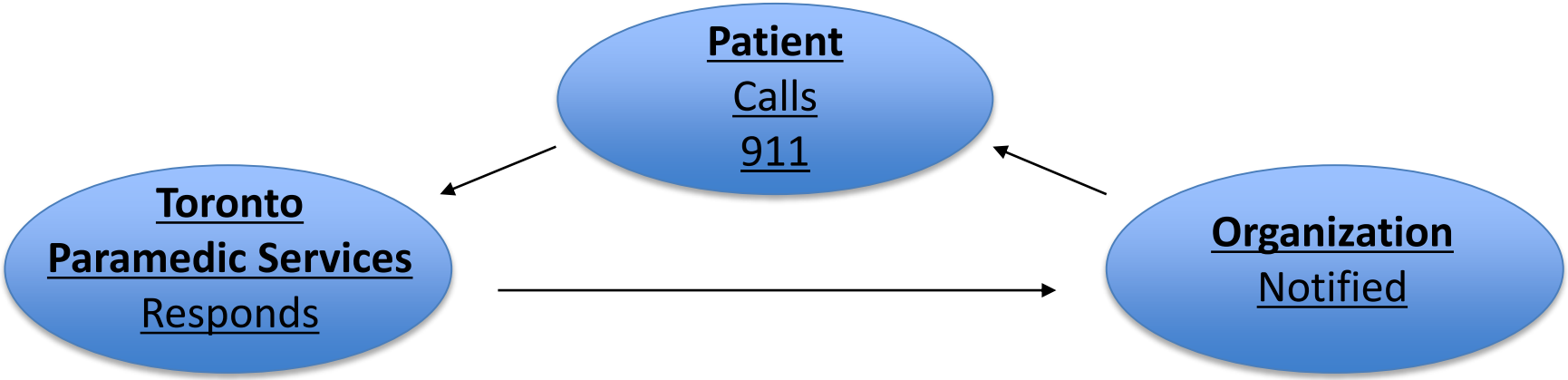
Practices from the Field

Keeping At-Risk High Needs Clients on the Radar – The Community Agency Notification (CAN) Program

Mary Eastwood
Director of the Don Valley Greenwood Health Link (DVGHL)
Interim Director of the Mid East Toronto Health Link (METHL)
(416) 645-6000 ext 1274
MEastwood@woodgreen.org

HealthLink
Don Valley Greenwood Health Link
Let's Make Healthy Change Happen

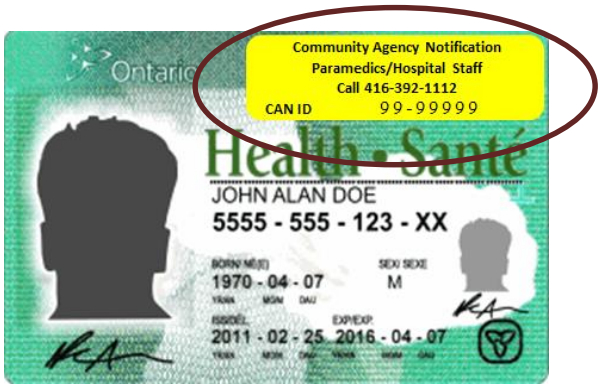
Community Agency Notification (CAN) Program



Community providers challenge is maintaining connection with clients who have complex health needs when they experience a medical emergency.

CAN is an innovative initiative partnering Toronto Paramedic Services (TPS) with community agencies to bridge the gap by providing **electronic notifications** when CAN clients call 911. CAN lets the agency know in "real time" client's name, if they were helped at home, taken to hospital, where they were taken, and when.

How the CAN Program Works



TORONTO PARAMEDIC SERVICES

When
Who
Where

The CAN Program is about keeping community providers connected to their clients when they have contact with Toronto Paramedics.

- Clients are registered to the program and provided a unique ID number that is put on their Health Card.
- When caring for a CAN registered client, paramedics can trigger a notification either by a phone call to an automated system or through their electronic patient care report.
- Notifications provide the “who”, “when”, and “where” of the 911 call.

CAN Notifications

- Notifications provide immediately actionable information
- Providers proactively follow-up with the person, family, or hospital to check on the client's condition.
- Inform circle of care including primary care provider
- Plan next steps including changes in service plan or update a coordinated care plan
- If an agency knows a client has been taken to hospital they can:
  - Connect with hospital social workers or discharge planners immediately and inform them of level of support available to client on return home
  - Case Worker can assist transition home and ensure any existing or new equipment or services required are ready on arrival
  - Ensures seamless transition for the client and decreases the chance of readmission to hospital or return visits to the ER

CAN Program Value

Value for Client

- Timely, cohesive follow up
- Sense of continuum instead of fragmented journey
- Supports notifying and involving primary care provider and circle of care including family/friends/ caregivers
- Wellness checks completed and new supports proactively put in place when needed
- CCP developed or updated when needed

Value for Hospital

- Community supports are identified and can provide information to hospital team
- Facilitates proactive case management, joint case conferencing, and discharge planning
- More efficient assessment and discharge planning can lead to shorter hospital stays

CAN Program Value

Value for Agency

- Effective use of resources
- Facilitates proactive case management
- Opportunity for client engagement, communication and to provide new or adjusted services
- Trigger to develop or update CCP
- Establishes link with Acute Care and Paramedic Services

Value for System

- Facilitates collaboration and proactive case management
- Supports communication with primary care providers
- Supports reduction in frequency of hospital readmission

CAN Notification Follow-Up Results

CAN Notifications received by WoodGreen staff from April 1 to June 30, 2015 facilitated the following results:

- 78 CAN notifications received
- 100% of notifications followed up by a phone call or visit
- 39% of situations required further follow up
- 41% of situations the circle of care within agency were informed
- 28% of situations the external circle of care were informed
- 24% of situations new services put in place
- 17 clients were admitted and in 82% of cases providers had contact with hospital

CAN Client Story

- 84 year old Cantonese speaking client living in Supportive Housing
- Admitted to hospital with lung issues and developed delirium in hospital
- ***Supportive Housing supervisor received CAN notification and therefore able to contact hospital and family immediately following admission***
- 3 weeks in hospital then transferred to rehab due to inability to eat solid foods need for g-tube for feeding – sharp decline from baseline
- Day after transfer supervisor went to see client and introduce herself to rehab team day to facilitate discharge – contact information shared & hospital team agreed to keep supervisor up-to-date to facilitate a safe and successful discharge
- Wife speaks only Cantonese and was feeling very concerned & distressed about husbands decline – supervisor provided appropriate support in Cantonese
- Client's daughter very involved with care and having trouble navigating health care system and feeling overwhelmed by the different care team staff involved – supervisor able to support effective system navigation and understanding of hospital care team's work

CAN Client Story

- Discharge meeting held at rehab hospital with all care team members. Client returned home with great improvement compared to admission, however, still with g-tube
- Services for personal care added as well as security checks with client and family's consent
- Client discharged with professional services through CCAC, including, Speech Language Pathologist, Nursing for g-tube care, and Occupational Therapist for in home safety assessment
- CCP meeting was held with client, client's wife and CCAC care coordinator – CCP quickly completed and shared with team including primary care provider
- Due to coordinated care support from care team, including family, client made almost full recovery. G-tube removed and is now able to eat without restrictions.

COLLINGWOOD G&M HOSPITAL

Practices from the Field

HealthLink South Georgian Bay Community
Let's Make Healthy Change Happen

Early Identification of Health Link Patients in Hospital for a Seamless Transition to Home

Lisa Vogel, O.T. Reg (Ont.)
Health Links Navigator
Georgian Bay Family Health Team
(705) 444-5885 ext. 630
lvogel@gbfht.ca
"Let's make healthy change happen"

Jennifer Stewart
Transition to Home Coordinator
Collingwood General and Marine Hospital
(705) 445-2550 ext 8204
stewartj@cgmh.on.ca
"Promoting positive partnerships in NSM LHIN"

CGMH is Home First Hospital

- Is a PHILOSOPHY☺
- HOME first is a province-wide, person-centered approach based on the expectation that patients who came to hospital from home will be discharged to home with appropriate community supports, once their acute treatment is finished.

COLLINGWOOD
G&M HOSPITAL

Early Identification

- CGMH screens all patients over the age of 65 for risk of readmission as well as those patients at risk to become ALC to LTC using the *TRST
- Transition to Home will assess the risk of all patients with a score of 3 or above, assess their health literacy, provide teaching and liaise with community partners. A plan is initiated using Home First Philosophy, barriers to discharge are identified and patients and families are prepared for their discharge on the day of their admission.
- **Triage Risk Screening Tool*

COLLINGWOOD
G&M HOSPITAL

Suspicion/Presence of the Following	
History of cognitive impairment-poor recall or not oriented	○ Yes ○ No
Difficulty walking/ transferring or recent falls	○ Yes ○ No
Five or more medications	○ Yes ○ No
ED use in previous month or hospitalized in past 3 months?	○ Yes ○ No
Lives alone and/or no available caregiver	○ Yes ○ No
ED Staff concerns?	○ Yes ○ No
ED staff concerns are:	☐ Nutrition/Weight ☐ Incontinence ☐ Failure to Cope ☐ Medication Issues ☐ Sensory Deficits ☐ Depression/Low Mood ☐ Other
Other concerns:	
TRST Score	
TRST Score	(0.0 - 6.0 points) Score of greater than 3 indicates ALC Risk Consider CCAC or Transition to Home Team Referral for admission avoidance

HealthLink
South Georgian Bay Community
Let's Make Healthy Change Happen

"Improving care for seniors"

- All patients that have a *TRST score of 3 or above are also screened for consideration/ eligibility for referral to Health Link.
- **ADMISSION AVOIDANCE FOR NON ACUTE PATIENTS**
- If admission is avoidable, Transition to Home will work through the same framework, engage community partners, family practice and prepare patient/family for transition back home once their non-acute care needs have been identified and a care plan has been initiated/enhanced.

- The ultimate goal of decreasing risk to patient from prolonged Hospital stay and to create capacity for our community members that require the acute care services that our Hospital provides.

HealthLink
South Georgian Bay Community
Let's Make Healthy Change Happen

Health Link Screening Tool

Assessment	
Patient Age:	○ Less than 65 yrs ○ 65 - 84 yrs ○ 85 yrs or older
Acute Care Admissions 6 months prior:	○ 0 ○ 1 ○ 2 ○ 3+
ED visits in the past 6 months:	○ 0 ○ 1 ○ 2 ○ 3+
Patient's discharge disposition:	○ Trans to Acute Care ○ Home with Support ○ Home w/o Support
Factors present:	☐ Lives alone ☐ Housing Issues ☐ Using Social Services ☐ Unemployed ☐ Language Barrier ☐ Using Comm. Services ☐ Low income ☐ Recent Immigration ☐ Government Assistance ☐ Median income
Conditions present:	☐ COPD ☐ GI Obstruction ☐ Mental Health Condition ☐ Diabetes ☐ Palliative Diagnosis ☐ Cirrhosis/Alcoh.Hepatitis ☐ Addiction ☐ Inflam. Bowel Disease ☐ Heart Failure w/o C.Angio ☐ Frail Elderly ☐ Other
Number of Conditions and Factors present:	○ 1 condition/factor ○ 2-3 conditions/factors ○ 4+ conditions/factors
Results	
Score:	
Results Indicate:	

HealthLink
South Georgian Bay Community
Let's Make Healthy Change Happen

Please complete form and fax to 705-444-1393
For more information about HealthLink call 211

Patient/Client Referral

Patient Identification			
Patient Name			
Date of Birth		Home Town	
Referral Information			
Hospital in-patient ☐	Emergency Department ☐	Primary Care Provider ☐	Other provider ☐
Date of Referral :			
Health Link Criteria (check all that apply)			
Multiple chronic/complex medical conditions ☐ *please provide diagnoses:*			
Mental health issues ☐	Addictions ☐	Palliative ☐	
Frail elderly ☐	Failure to cope at home ☐	Care-giver stress ☐	
Social isolation ☐	Economic issues ☐	Cognitive impairment/ dementia ☐	
Access to Primary Care			
Patient has a Primary Care Provider?	Yes ☐	No ☐	
Primary Care Provider Name:			
Consent			
Patient has agreed to be contacted by the Health Link ☐			
Please Submit Form to the Health Link Coordinator			

The Transition to Home Team faxes &/ calls referrals to the Health Link Coordinator depending upon the urgency.

The Health Links Screening Tool score as well as the patient location in CGMH are indicated on the referral.

HealthLink
South Georgian Bay Community
Let's Make Healthy Change Happen

Referral Process

When the Health Link Coordinator receives a referral the patient is assigned a Navigator from the "most responsible provider." In South Georgian Bay this could be from the:

- Georgian Bay Family Health Team
- North Simcoe Muskoka CCAC
- South Georgian Bay Community Health Centre
- Breaking Down Barriers
- Hospice Georgian Triangle
- CGMH

Referrals are forwarded by the Health Link Coordinator to the Navigator within 24hrs or sooner, if required (i.e. admission avoidance in the ED) to make contact with the patient.

HealthLink
South Georgian Bay Community
Let's Make Healthy Change Happen

Health Link working with Patients in the CGMH Emergency Department

When the opportunity presents itself, the Health Link Coordinator or Navigator will meet with the patient in the Emergency Department to:

- Collaborate with the Transition to Home Team in the emergency department re: reason for referral & discharge plan
- Explain the Health Links program to the patient&/caregiver
- Obtain consent for participation
- Schedule a meeting for post-discharge to complete the Patient Interview & Coordinated Care Plan with patient&/caregiver in the community

HealthLink
South Georgian Bay Community
Let's Make Healthy Change Happen

Health Link working with CGMH Inpatients

- Health Link Coordinator or Navigator collaborates with the Transition to Home Team & CGMH staff to discuss reason for referral, care plan and determine the estimated discharge date.
- The Health Link Coordinator or Navigator will meet with the patient within 24-48 hours of receiving the referral to explain the Health Links program, and obtain consent for patient/caregiver participation in the program. During this visit &/ subsequent visits while in hospital the Health Link Navigator will initiate the Patient Interview and completion of the Coordinated Care Plan.
- CGMH Transition to Home Team will notify the Health Link Navigator of the patient discharge and ensure the discharge plan/summary is shared.
- The Health Link Coordinator/Navigator will follow up 24-72 hours post-discharge either by telephone or a home visit based on the patients needs/situation.

HealthLink
South Georgian Bay Community
Let's Make Healthy Change Happen

Think Tank

- The Navigator will arrange to present the Patient's Story at a Think Tank Teleconference if the Patient Interview reveals a complex situation that could involve many varying services.

- The Think Tank is a regular teleconference attended by the Patient, the Care Team and representatives from many of the local health and community services. Participants brainstorm on ideas to improve services for the patient and help them to move toward meeting their goals.

HealthLink

South Georgian Bay Community

Let's Make Healthy Change Happen

COLLINGWOOD
G&M HOSPITAL

Early Identification of Health Links Patients in Hospital for a Seamless Transition to Home: Patient Story

HealthLink
South Georgian Bay Community
Let's Make Healthy Change Happen

Next Steps…

COLLINGWOOD
G&M HOSPITAL

- Continue to work towards reducing duplication of services. For example the CGMH Transition to Home Team provides a follow up telephone call 24 hours post-discharge for all patients returning home on the "Hospital to Home" program. Health Link patients also receive post-discharge follow-up from the Coordinator or Navigator.

- Ongoing development of "Best Practices" for Health Link care provision – SGBHL participation in IDEAS training Cohort 10

- Implementation of the SGBC Health Link Provider Portal hopefully by November 2016 to make it easy for care teams to collaborate on the care for their patients. The portal allows secure communication between care team members, and allows appropriate access to required information and documents about their patients and their care.

- Revision of Health Link referral form to ensure user friendliness & decrease duplication of work

- Ongoing Health Link education to be provided to health care service providers & the SGB community.

HealthLink

South Georgian Bay Community

Let's Make Healthy Change Happen

COLLINGWOOD
G&M HOSPITAL

IMPLEMENTING INNOVATIVE PRACTICES IN YOUR HEALTH LINK

Discussion;

Please submit questions to us via the "Question" box.

HEALTH LINK LEADERSHIP COMMUNITY OF PRACTICE;

Resources and Events

Transitions Between Hospital to Home

Webinar PART ONE- **October 14th, 2016 (today!)**
Webinar PART TWO- **November 16th, 2016**

Also…

Health Quality Transformation 2016

October 20th, 2016. *Registration is now closed, reached capacity! Thank you and we look forward to seeing you there!*

Polling

Ontario

Health Quality Ontario

www.HQOntario.ca

FOLLOW@HQOntario