Seamless Transitions: Hospital to Home – Guidebook

A guide for improving patient transitions from hospital to community

Trillium Health Partners and Mississauga Halton CCAC partnership initiative

June 2015
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Section 1

Overview
1.1 Seamless Transitions overview

Effective transition from acute care to community care is an essential element of high quality patient care and is a core business of hospitals and Community Care Access Centres (CCACs). Transition planning is most effective when hospitals, community providers and primary care physicians work together to coordinate care for patients.

It is well known that admission and discharge from hospital can be a stressful and challenging time for patients and families. Some people will return to their usual way of life following diagnosis, treatment and rehabilitation in acute (hospital) care settings. Others will require additional support to enable them to return to and recover in the community. Patients’ needs cannot be met by hospital and community organizations working in silos. As such, hospital, community and primary care providers must better integrate transition planning practices to enable more patients to experience a smooth, effective and safe care journey from hospital to home. In addition, there is growing consensus that the health care system needs to deliver improved value for money, while simultaneously improving outcomes and quality. This cannot be achieved without improved integration among providers and more care closer to home – where patients want to be.

Seamless Transitions: Hospital to Home is a multi-year, formal partnership initiative, funded by the Mississauga Halton Local Health Integration Network (MH LHIN). The initiative is aimed at improving health care delivery through the development of a consistent, integrated, person-centered approach for hospital to home transitions. The Seamless Transitions: Hospital to Home approach eliminates duplication in processes and gaps in communication and care that put patients at risk, thereby improving the patient experience.

This Guidebook outlines the steps taken by the Mississauga Halton CCAC and Trillium Health Partners (THP), in equal partnership, to better integrate care for patients being discharged from hospital to home/community. It is intended not only to document the partnership journey and design process, but to serve as a resource or blueprint for other hospital and community organizations to use to implement new models of transition planning, focused on better integrating care for patients.

Lack of integration results in:

- Delays in discharges
- Inappropriate use of resources
- Poor patient & caregiver experience
- Poor connectivity and continuity between hospital and community providers
Mississauga Halton CCAC and Trillium Health Partners (THP) formal partnership

- Is purposeful, aligned to each organization’s respective strategic plans and shaped by a shared vision. It is guided by agreed upon partnership principles.
- Is committed to capacity building in order to better serve the health needs of their community.
- Places patients at the centre of the work, taking a systems-based approach to optimize the impact of their respective resources with jointly-owned processes.
- Shares in the risk and benefits.

Mandate (from the Steering Committee):

Go out and be disruptive innovators!

Strive for transformational change, not incremental change (day-to-day service improvement).

"Transformation is a deliberate, planned process that sets out a high aspiration to make dramatic and irreversible changes to how care is delivered, what staff do (and how they behave), and the role of patients, which results in substantial, measurable improvement in outcomes, patient and staff satisfaction and financial sustainability."
1.2 **Seamless Transitions** approach and timeline

Quick Tip:
Moving quickly from design to testing enables timely feedback and observations to support rapid changes and frequent refinement of the approach.
Section 2

Design Process
2.1 Define

The purpose of this step was to craft a meaningful and actionable problem statement. This guiding statement should focus on patient needs and experience, using insights from patients, caregivers and providers.

How did we gain insight?

We engaged patients and caregivers.

- Interviewed 50 patients (in hospital and at home)
- Members of the Mississauga Halton CCAC *Share Care Council* (a patient and family advisory forum) were asked to comment about their experiences with hospital to home transitions – to identify gaps and/or opportunities for improvement
- Included a patient and caregiver on the Design Team

We engaged staff from the hospital, CCAC and community providers.

- Over 100 staff members, across disciplines, were interviewed
- Asked the design team members, comprised of frontline hospital and community staff, to share their experiences (personal or professional) with discharge planning processes
- Design team members observed in-hospital and CCAC community discharge processes
What we learned

<table>
<thead>
<tr>
<th>Patients</th>
<th>Care providers and Design Team observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>● I need to know that I am not alone when I leave hospital</td>
<td>● The discharge processes need to be simplified and standardized across units, sites and organizations</td>
</tr>
<tr>
<td>● I want to know a discharge date as soon as possible, ideally the first day in hospital</td>
<td>● There is a tremendous amount of duplication in processes</td>
</tr>
<tr>
<td>● I need a life plan – a personalized package provided before leaving the hospital, including a written transition plan that can be shared with my family and caregivers, what to expect in the first few weeks after returning home and the names and phone numbers of 24/7 resources</td>
<td>● There is no single system or set of resources that everyone (hospital &amp; community) has access to</td>
</tr>
<tr>
<td>● I want to be set up to be successful at home to prevent re-admission</td>
<td>● There is a lack of patient-centeredness – tasks are not always patient focused</td>
</tr>
<tr>
<td>● I need a person that is not rushed, that will spend time with me, e.g., explain what is going to happen, train me in equipment being used, make sure I am comfortable, provide contact information</td>
<td>● Access, timeliness and quality of information and resources is a challenge</td>
</tr>
<tr>
<td>● I need someone who is sensitive to my cultural needs/situation – this does not have to be a clinical person</td>
<td></td>
</tr>
</tbody>
</table>

In developing the problem statement, the team considered the themes identified when interviewing staff and patients. These themes were amalgamated to articulate an actionable problem statement that drove the rest of the design work.

**Problem Statement**

We lack a shared understanding of patients’ needs to inform and execute a care plan that will give them confidence to leave hospital.

“Framing the right problem is the only way to create the right solution.”

**Quick Tip:**

A good problem statement is one that:

● Is discrete and specific
● Provides focus and frames the problem
● Inspires the team
● Informs criteria for evaluating competing ideas
● Captures the hearts and minds of stakeholders
2.2 Brainstorming

The focus of this step was to transition from identifying problems to creating solutions. The goal was to generate many ideas, then select the best solutions.

“It’s not about coming up with the ‘right’ idea; it’s about generating the broadest range of possibilities.”

How did we approach brainstorming?

The team developed “How might we...” questions that flowed from our problem statement. We held five brainstorming sessions and challenged participants to generate 200 “out of the box” ideas per session about how hospital to home transitions might be improved, based on five questions:

1. How might we better communicate with patients and families about going home?
2. How might we better share information about patients with members of the care team?
3. How might we better involve community providers in patient care before patients leave hospital?
4. How might we better collaborate to optimize resources in our community?
5. How might we reduce wasted time/ duplication in our work?

We exceeded our goal, engaging 154 staff and generating 1,301 ideas.

Common themes: shared health record accessible by all, start transition plan at admission, patient binder and calendar, transition education checklist for patients and staff, dedicated CCAC worker to unit, community providers coming into hospital to meet patients/team, bedside rounds, one assessment, patient portal, a shared eHealth record assessable by all, case conferencing with previous providers
In order to avoid losing all of the innovation potential generated through brainstorming, a process of considered selection was established. After each brainstorming session, participants were asked to vote and select the top three ideas that were generated. Those ideas were carried forward into the prototyping phase. The team also gathered information from the patient’s perspective through the Mississauga Halton CCAC’s patient and advisory forum – the *Share Care Council*. A leading practice review and environmental scan were also completed. Information obtained from all sources informed the design of the new approach.

**Design Principles (for integrated transition planning)**

- The transition from hospital to home must be patient-centered.
- The engagement and active participation of patients and their family as equal partners is central to a successful transition and the delivery of care.
- Effective transition planning is facilitated by a “whole system approach.”
- Effective integrated transition planning should be consistent for all patients receiving care in the health care system.
- Transition planning is a process and not an isolated event. It should be commenced at the earliest opportunity – prior to admission for planned admissions and as soon as possible for all other admissions.
- Transition planning should be done by a named person who has responsibility for coordinating all stages of the ‘patient journey’. This involves connecting with the pre-admission service providers (primary care physician, CCAC community care coordinator, etc.) at the earliest opportunity and reconnecting at the time of discharge. Staff should work within an integrated framework of interprofessional and multi-agency teams to manage all aspects of the transition process.
- Apply Lean principles in designing transition process.

(Adapted from: *Improving patient transitions from hospital to community: a good practice guide* )

**Quick Tip:**

Use design principles to help make design decisions.
2.3 Prototype – our new approach

The goal for this step was to build a patient-centered approach that improved the continuity of care for patients from admission through discharge to recovery at home or in the community.

How did we approach prototyping?

The design team created a storyboard that outlined the new process. Once the first draft of the storyboard was completed, various stakeholders reviewed the process and their feedback was used to refine the prototype.

- **Step 1**: Transition planning on admission
- **Step 2**: Transition planning during hospital stay
- **Step 3**: Transition planning at discharge
- **Step 4**: Transitioning from hospital to home

**Quick Tip:**

"Build to think and test to learn."
Seamless Transitions: Hospital to Home

The Seamless Transitions process begins upon decision to admit and ends two weeks post-discharge. It is a pull system that permits earlier identification and management of patients streamed as routine or complex and timely discharges for patients streamed as simple. In this process the Transition Coordinator can either be a social worker/discharge planner (SW/DCP) or a CCAC care coordinator (CC). The process is focused on meeting patient needs in the most appropriate setting, by the most appropriate provider and in the most cost effective manner.

Quick Tip:

To be successful, design the process first. Then, organize the people into their teams and/or roles.
## What's Different?

<table>
<thead>
<tr>
<th>Current practice</th>
<th>New Seamless Transitions approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Social Worker or Discharge Planner oversees discharge planning for some patients – by referral</td>
<td>• Transition Coordinator (social worker/discharge planner or CCAC care coordinator) oversees all the transition planning for any given patients</td>
</tr>
<tr>
<td>• Duplicate assessments and multiple places to document</td>
<td>• One member of the care team acts as the coordinating point of contact for staff, patients, families, community providers, making navigation of the transition process easier.</td>
</tr>
<tr>
<td>• Siloed hospital and CCAC care teams - CCAC care coordinator engaged in discharge planning after referral from hospital care team (most times after patient medically stable) – occurs later on in patient acute care stay</td>
<td>• A standardized assessment process and care management system is established for all patients</td>
</tr>
<tr>
<td>• Unit-based care teams</td>
<td>• Care is integrated around the patient (not around providers or organizations) - mobile care teams include a CCAC care coordinator as a member of the integrated care team</td>
</tr>
<tr>
<td>• Limited engagement of community care teams - inconsistent notification to community teams and family physicians when patient admitted to and discharged from hospital</td>
<td>• Allows for improved and more timely information sharing between hospital teams and hospital and community care team members - <em>My Story + Post-Hospital Plan of Care</em> travel with the patient from hospital to community</td>
</tr>
</tbody>
</table>

A traditional approach where hospital care teams are geographically based and hospital and community teams are siloed.

An integrated approach, grounded in leading practice, designed to deliver high quality, efficient, effective, integrated care that connects care providers across the continuum to improve the patients' experience.
Key components

Component 1: Integrated Mobile Care Team

- **Change Concept**: Team-based approach to care where an interprofessional team works together clinically and consults one another to collaboratively plan transitions out of hospital for patients. The team enables decisions about a patient to be informed by all aspects of patient care, and ensures that the plan clearly identifies what is required and by whom in planning for seamless transitions.
  - Team follows patients on one physician caseload from point of admission through to discharge and recovery at home. Teams are organized around a group of patients, rather than being unit-based.
  - Each care team consists of a dedicated physician, transition coordinator (TC), physiotherapist and occupational therapist. Other allied professionals are engaged as needed.

- **Tools or resources**:
  - Standard work
  - Blackberries
  - Discharge rounds
  - *My Story*
  - *Plan of Care*

Component 2: Enhanced care coordination – Transition Coordinator (TC) role

- **Change Concept**: One member of the integrated care team (SW/DCP or CCAC CC) who acts as the single point of contact for transition planning, and is the main connection between the care team, community providers and patients and families from point of admission through to recovery in the community. The role facilitates the safe and timely discharge of patients by preparing patients for hospital discharge, assisting them to transition from hospital to home and supporting them after discharge through follow-up phone calls and visits as needed. In essence, the role is responsible for enabling the planning, navigation, communication and coordination of transition planning.

- **Tools or resources**
  - Standard work
  - Job description
  - List of skills and competences
  - *My Story*
  - *Plan of Care*
Component 3: Transition planning starting on admission

- **Change Concept:** A baseline assessment that paints a picture of the patient as they initially present at admission is completed. Assessment initiated at admission, regardless of where patient is, including the emergency department (ED). Information is collected regarding the patient’s presenting concerns and their ability to manage the activities of living (these may be health or social related). Patients are then streamed into transition pathways based on their anticipated post-hospital care needs and an initial transition plan is established.
  - Simple = no post-hospital services required (A simple transition is one where the patient returns home with simple or no ongoing health needs, which can be met without complex planning.)
  - Routine = one post-hospital service required
  - Complex = two or more post-hospital services required (A complex transition is one where there may be several agencies involved in the transition plan and arrangements are complex and interdependent, requiring many case conferences or family meetings.)
  - Engage existing community providers and primary care to gather information to build My Story.
  - Rapport established early between patient and care team to build trust and encourage communication. This enables patients to be active participants in their care planning and gives them comfort knowing what will happen next and who to ask for help or information.

- **Tools or resources:**
  - Transition Pathway principles
  - My Story
  - Plan of Care
  - My Care Guide

Component 4: Comprehensive, individualized written transition plan – My Story and Plan of Care

- **Change Concept:** Shared resources for transition planning that are updated by all members of the care team in language that is easily understood by patients. Documents contain pertinent information about health history, functional status and treatment plans so patients and providers do not have to repeat information and are working toward shared goals.
  - My Story – a baseline assessment initiated within 24 hours of admission that includes the patient’s health, social and functional status and travels with the patient after they leave hospital.
  - Plan of Care – provides summary of hospital events to community providers to support continuity of care based on patient’s goals, functional status and psychosocial supports.
• My Care Guide – Summary of instructions/recommendations for patients from hospital care team for ongoing management of condition, as well as contact information for care team members in community and a calendar of important appointments.

• **Tools or resources:**
  - *My Story*
  - *Plan of Care*

**Component 5: Discharge rounds**

• **Change Concept:** Table (non-bedside) rounds occur daily at a consistent time. All members of the interprofessional team attend and provide updates on patients to identify and work through barriers to discharges. Other allied attended as needed. The expected discharge date and plan is reviewed and amended if/as needs change or treatments alter.

• **Tools/Resources**
  - Dedicated, consistent meeting place

**Component 6: Post-discharge follow-up calls and/or visits**

• **Change Concept:** Transition Coordinator contacts every patient post-discharge to confirm transition plan is being followed, services are being delivered in the community and to address patient concerns. In addition, home visits are completed based on need (typically only for complex patients).
  - Simple = called 24 to 48 hours after discharge
  - Routine = called 48 to 72 hours after discharge.
  - Complex = called within a week after discharge

• **Tools/Resources**
  - Call log and progress note

**Component 7: Timely, accurate information flow – from community providers ☵ amongst hospital teams ☵ back to community providers**

• **Change Concept:** Primary care physicians, community care coordinators and other members of the patient’s circle of care will be informed of the patient’s admission and have an opportunity to provide relevant information to in-hospital care team members to support early transition planning.

• **Tools/Resources**
  - *My Story*
- *Plan of Care*
- Dedicated fax machine and office space with phone
### Transition Coordinator

<table>
<thead>
<tr>
<th>Activities</th>
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<tbody>
<tr>
<td>- Obtain patient list from Meditech and confirm with MRP</td>
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<tr>
<td>- Review chart on unit</td>
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<tr>
<td>- Visit patient in ED or on unit</td>
</tr>
<tr>
<td>- Initiate My Story within 24 hours of admission</td>
</tr>
<tr>
<td>- Identify need for PT or OT referral based on information gathered for My Story</td>
</tr>
<tr>
<td>- Contact family physician and notify them of patient's admission - if no family MD, find one for patient using Health Care Connect</td>
</tr>
<tr>
<td>- If patient on community services, contact CCAC care coordinator to put services on hold in CHRIS</td>
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<tr>
<td>- Stream patient into transition pathway</td>
</tr>
<tr>
<td>- Communicate with team throughout day via text/calls</td>
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<tr>
<td>- Review patients daily</td>
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<tr>
<td>- Check in with primary nurse, charge nurse and flow nurse to identify/ work through barriers to discharge</td>
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<tr>
<td>- Identify members of care team required</td>
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<tr>
<td>- Facilitates daily discharge rounds</td>
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<tr>
<td>- Set up and facilitate family meetings as needed</td>
</tr>
<tr>
<td>- Coordinate health teaching for patients and families</td>
</tr>
<tr>
<td><strong>Routine/Complex Patients:</strong></td>
</tr>
<tr>
<td>- Coordinate completion of required discharge summaries from allied health</td>
</tr>
<tr>
<td>- Set up assessment at discharge destination</td>
</tr>
<tr>
<td>- Compile referral forms for community support and CCAC services</td>
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<tr>
<td>- Notify family physicians of discharge and fax Plan of Care</td>
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<tr>
<td>- Fax prescriptions to pharmacy</td>
</tr>
<tr>
<td><strong>Routine/Complex Patients:</strong></td>
</tr>
<tr>
<td>- Scan Plan of Care and My Story in CHRIS system</td>
</tr>
<tr>
<td>- Share Plan of Care with CCAC community care coordinator</td>
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<tr>
<td>- Confirm delivery of equipment and supplies</td>
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<tr>
<td>- Provide resources and education materials to patients and families, including My Story and Plan of Care</td>
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<tr>
<td>- Complete follow-up phone call (based on transition pathway timelines)</td>
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<td>- Conduct home visit and case conferences as needed</td>
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### Most Responsible Physician (MRP)

<table>
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<tr>
<th>Activities</th>
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<tbody>
<tr>
<td>- Check in with team Monday morning (when rotation/week begins)</td>
</tr>
<tr>
<td>- Receive/provide update on caseload, patient statuses, weekend events</td>
</tr>
<tr>
<td>- Communicate with team throughout day via text/calls</td>
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<tr>
<td>- Attend daily team rounds - identify discharges for next day</td>
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<tr>
<td>- Sign off on medical referrals</td>
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<tr>
<td>- Fill out required health reports</td>
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<tr>
<td>- Completes discharge summary prior to discharge (ideally 24 hours prior to discharge)</td>
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<tr>
<td>- Sign off on discharges by 10AM</td>
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<tr>
<td>- Be responsive to follow-ups from primary care or community pharmacists</td>
</tr>
</tbody>
</table>

### Physiotherapist (PT) and Occupational Therapist (OT)

<table>
<thead>
<tr>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Check in with team and obtain patient list</td>
</tr>
<tr>
<td>- Visit patient in ED or on unit</td>
</tr>
<tr>
<td>- Initiate My Story within 24 hours of admission</td>
</tr>
<tr>
<td>- Communicate with OTA/PTA for assigned care</td>
</tr>
<tr>
<td>- Communicate with team throughout day via text/calls</td>
</tr>
<tr>
<td>- Attend daily team rounds - updates on patients’ progress/identify need for community referrals</td>
</tr>
<tr>
<td>- Complete My Story and Plan of Care</td>
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<tr>
<td>- Participate in family meetings</td>
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<tr>
<td>- Educate patients’ families on post-discharge care</td>
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<tr>
<td>- Prioritize patients to see based on transition pathways/discharge date and plan</td>
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<tr>
<td>- Complete documentation to support transfer of information to community providers</td>
</tr>
<tr>
<td>- Communicate with external providers as needed</td>
</tr>
<tr>
<td>- Follow up with community OT/PT as needed</td>
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</tbody>
</table>
## Anticipated benefits of *Seamless Transitions* approach

<table>
<thead>
<tr>
<th>Benefits for patients</th>
<th>Benefits for caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Confident that transition needs are met</td>
<td>• Feel valued as partners in the transition planning process</td>
</tr>
<tr>
<td>• Able to maximize independence</td>
<td>• Their experience is heard and acknowledged</td>
</tr>
<tr>
<td>• Feel part of care process – an active, empowered partner and decision-maker</td>
<td>• Feel confident of continued support in their caring role</td>
</tr>
<tr>
<td>• Do not experience unnecessary gaps or duplication in effort</td>
<td>• Have the right information, advice and training to help them in their caring role</td>
</tr>
<tr>
<td>• Understand their care plan, know what will happen next and who to contact</td>
<td>• Are given options for caregiving roles</td>
</tr>
<tr>
<td>• Experience care as a coherent pathway, not a series of unrelated activities</td>
<td>• Understand what has happened and who to contact</td>
</tr>
<tr>
<td>• Have confidence they will be supported after leaving hospital</td>
<td>• Have confidence their loved one will be supported in the community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits for staff &amp; physicians</th>
<th>Benefits for the health system</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Feel their expertise is recognized and used appropriately</td>
<td>• Resources are used effectively</td>
</tr>
<tr>
<td>• Receive key information in a timely manner</td>
<td>• Providers work together differently (e.g. integrated services, improved communication, collaborative planning process, stronger link between hospital, community and primary care providers)</td>
</tr>
<tr>
<td>• Understand their part in the system and their role on the integrated care team</td>
<td>• Higher quality care through leading practice implementation</td>
</tr>
<tr>
<td>• Develop new teambuilding skills</td>
<td>• Cross-boundary alignment of goals – shared accountability for system performance</td>
</tr>
<tr>
<td>• Feel as though they are working on a team focused on well-understood and shared goals for patients</td>
<td>• Reinforced collaborative approach to system planning and design</td>
</tr>
</tbody>
</table>
2.4 Test

The focus of this step was to verify original design assumptions versus actual performance and refine and validate solutions.

The Medicine program at THP-Credit Valley Hospital (CVH) site was selected as the test area. The new approach was originally tested with one team and one physician caseload. The team consisted of a physician, physiotherapist, occupational therapist and transition coordinator (TC). The TC role required both the skills and competencies of the social worker/discharge planner role and the in-hospital CCAC care coordinator role. Additional and enhanced capabilities required to function in the TC role were determined as driven by the design. Therefore, the TC role was tested as a dyad. In this dyad, a CCAC care coordinator and a THP social worker/patient navigator working in tandem to perform the necessary standard work/task to plan for transition home. The dyad utilizes a case management model where patients are reviewed on admission and then assigned to a TC caseload (SW/DCP or CC) based on presentation and anticipated post-acute care needs.

No criteria or selection process was utilized to select patients for the test; the patients in the test group were an unbiased representation of the patient population across the Medicine program. A dedicated team tested the process except for physicians, who rotated through the process every two weeks, based on their current rotation schedule. Eleven physicians participated in the test over the 39 week period.

Quick Tip:

“What: Key components of Seamless approach

Where: Medicine program at Trillium Health Partners - Credit Valley Hospital (THP-CVH)

When: September 29, 2014 to June 26th, 2015

Who: Patients on two physician teams (started with one physician team, the test was expanded to include a second team on January 21, 2015)
Refining the approach

Plan-Do-Study-Act (PDSA) cycles were used for testing the changes – or the key components of the Seamless approach, by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). A PDSA worksheet was completed for each component tested. The PDSAs were reviewed on a weekly basis and adjustments were made based on learnings from the previous cycle. Listed below is a synopsis of our findings.

<table>
<thead>
<tr>
<th>Components</th>
<th>Observations/Learnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated mobile care team</td>
<td>Attitudes towards transition planning and the importance of cooperation and collaboration between the various health care providers has changed considerably with a greater emphasis on the significance of the interprofessional approach to patient care. Co-location of the team facilitated knowledge transfer, improved communication and supported relationship building. All team members working towards one goal led to increased accountability for individual roles in the transition planning process.</td>
</tr>
<tr>
<td>Enhanced care coordination - Transition Coordinator (TC) role as a dyad</td>
<td>The TC role provided one true source of information regarding transition planning and is the link between the patient and the team. The role brought about a more coordinated approach to the transition process and more involvement of the interprofessional team. In addition, the role facilitated improved communication with patients and families enabling them to be more involved and better manage after their hospital stay. Testing as a dyad allowed for the interchange of staff across the two sectors, promoting a shared understanding of transition issues and enabled better synchronization of resources as part of the process.</td>
</tr>
<tr>
<td>Transition planning starting on admission</td>
<td>By assessing patients at admission, team members were able to identify the need for and perform more timely assessments. In addition, psychosocial and functional needs could then be addressed in tandem with medical care needs. Early transition planning reinforced more streamlined and efficient processes of care (created a pull versus push process of care) and contributed to improved quality and safety of patient care.</td>
</tr>
<tr>
<td>Comprehensive, individualized written transition plan – My Story and Plan of Care</td>
<td>The Plan of Care, which includes contact information for all hospital and community service providers, outlines community care plans and follow-up appointments, lists medications and summarizes all health issues addressed during the hospital stay. It is a valuable tool for patients and their families. Similarly, the Plan of Care is a valuable tool for patients and their families.</td>
</tr>
<tr>
<td><strong>Seamless Transitions: Hospital to Home</strong></td>
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<tr>
<td>Knowledge of pre-admission services as identified in <em>My Story</em> facilitated appropriate redirection of community care services upon discharge. It is an important tool that serves as a single source of truth establishing patients’ baselines and projected transition plans.</td>
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<thead>
<tr>
<th><strong>Discharge rounds</strong></th>
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<tr>
<td>Both bedside and table rounds were trialled. Travel time about the hospital for bedside rounds made this process inefficient. As such, bedside rounds are only done for specific patients as identified by team members. Table rounds were trialed at different times during the day and it was determined that rounds at 1:00 p.m. worked well, as the team had an opportunity to assess new patients, complete preparations and confirm plans for the next day’s discharges. Charge nurses were not consistently able to attend rounds so received updates from the TC or flow nurse.</td>
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<tr>
<th><strong>Post-discharge follow-up calls and/or visits</strong></th>
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<tr>
<td>Initially, only patients streamed as routine or complex received follow-up phone calls after discharge, within identified timelines. A review of the data indicated that patients streamed as simple were returning to the ED in some cases for issues that could be resolved elsewhere. As such, all patients now receive follow-up calls. The timing of the calls were amended based on feedback from complex patients indicating that they were receiving too many calls within the first 48 hours after discharge.</td>
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<tr>
<th><strong>Timely, accurate information flow – from community providers ↔ amongst hospital teams ↔ back to community providers</strong></th>
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<tbody>
<tr>
<td>Timely, more consistent communication has improved working relationships between staff within the hospital, and between the hospital and the broader community. Community services providers are more aware of patients that are coming onto their caseload – warm handoff. Primary care physicians more aware of the status of their patient once they have been hospitalized – discharge summary, <em>Plan of Care</em> with goals and list of medication helpful in continuity of care.</td>
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Section 3

Evaluation
3.1 Evaluating the Seamless approach

Although THP and the Mississauga Halton CCAC started working in partnership in January 2014, testing of the new integrated Seamless Transitions approach started in September 2014 with funded from the MH LHIN. It may be too early to see clear benefits resulting from the changes that have been made. Key outcomes, processes, and balancing measures have been analyzed to help determine the benefits of the new approach. Measurement is a critical part of testing and implementing change; measures tell a team whether the changes they are making actually lead to improvement. The following is a snapshot of measures tracked while testing the Seamless approach.

Outcome measures:

How does the system impact the values of patients, their health and wellbeing? What are impacts on other stakeholders such as funders, employees, or the community?

- Patient experience
- Length of stay
- Alternate Level of Care (ALC) days and rates
- Percentage of patients discharged home with support

Process measures:

Are the parts/steps in the system performing as planned? Will this impact system benefits?

- Average time from admission to first patient visit by TC (initiation of My Story)
- Percent of patients’ primary care physician notified within 24 hours of discharge (Plan of Care faxed)
- Percentage of patients that received a Plan of Care on discharge
- Percent of follow-up phone calls made within established post-discharge criteria

Balancing measures:

Are changes designed to improve one part of the system causing new problems in other parts of the system?

- Compare readmission rate for Seamless Transitions patients with those under current processes
3.2 Qualitative measures

Post-discharge phone calls

Post-discharge phone calls are used to promote patient satisfaction and safety, potentially reducing re-admissions. These calls help identify post-discharge issues and subsequent needed interventions. The focus of the calls is to ensure the care plan established in hospital is being carried out in the community.

Post-discharge interviews

As of April 2015, the Seamless Transitions team has completed 50 post-discharge interviews with Seamless patients. The team asked patients and their caregivers/family members to comment on a number of aspects of the transition planning process to understand the outcomes from a patient perspective.

- Communication among health care staff about patient’s health/transition plans
- How involved patient was in transition planning
- Transition package – how was it helpful, any suggested changes
- How confident they felt with the arrangements made for discharge

<table>
<thead>
<tr>
<th>Communication</th>
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<tbody>
<tr>
<td>- Overall good communication between health care practitioners – team approach observed for discharge planning</td>
</tr>
<tr>
<td>- If patient was asked to repeat info, it was for clarification purposes mostly</td>
</tr>
<tr>
<td>- Practitioners adapted communications to patient/family preferences (e.g. care conference, over phone, etc.)</td>
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<tr>
<td>- Communication gap: handover between physicians</td>
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<tr>
<td>- Opportunity: communicate discharge date sooner, share reasons for delays</td>
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<tr>
<th>Support along the continuum</th>
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<tr>
<td>- Felt supported from point of admission through to discharge</td>
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<tr>
<td>- Especially liked accessibility and support of transition coordinator</td>
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<tr>
<td>- Appreciated coordinated post-hospital plan, including scheduled appointments in calendar and prescriptions faxed to pharmacy</td>
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<tr>
<td>- Many believed their situation was unique, but felt their needs were met regardless</td>
</tr>
<tr>
<td>- Common thread: transition coordinator truly cared – even after discharge</td>
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<tr>
<th>Discharge package</th>
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<tr>
<td>- Service providers, family doctors and family members all knowledgeable of package</td>
</tr>
<tr>
<td>- Prompted phone call from specialist day after discharge</td>
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<tr>
<td>- Been brought to emergency department (ED)</td>
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<tr>
<td>- Found to be useful, well-organized, detailed and helpful in providing direction – calendar, list of prescriptions and contact numbers considered the most helpful</td>
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<tr>
<td>- No recommendations for change</td>
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<tr>
<th>Confidence at discharge</th>
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<td>- Comfortable, but wouldn’t use the word “confident”</td>
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<tr>
<td>- Compared to previous experiences leaving hospital, one patient felt great because they didn’t feel abandoned</td>
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<tr>
<td>- Often patients felt stress during transition out of hospital, but more confidence when home and experiencing actions set out in care plan</td>
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<tr>
<td>- Experienced delays to discharge because paperwork was not completed by physicians</td>
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What we heard from patients or caregivers about their **Seamless Transitions** experience

- "It's not the first time I have taken my Mom to the hospital - this discharge was more detailed - especially with the booklet - sometimes when you leave, you forget little things but since the booklet was there, I can look back and review. The booklet and communication with the family doctor is an excellent idea. The whole team was involved with her care."

- "The discharge process was great. I did not feel like I was left out in the wind." (compared to a previous experience)

- "The discharge was well organized. This time, there was a team approach – everyone was talking to one another." (compared to a previous experience)

- "You guys have an amazing team. If every family that goes through this experience gets this type of support, in such an organized way, it would be very helpful, especially for older people. Everywhere I go, if I go to the cardiologist, I take the booklet with me – everything is there, extremely helpful. The team you put together is an amazing team, thank you for the system you have put in place."

- "The discharge book is wonderful, I don’t have to repeat my story (to community providers) they can just read the book. My primary care physician said to me she received everything from the hospital – the test results and recommendations – we went through everything. It makes me feel good to know that I can bring the book to my appointments. I was terribly impressed. I thought it was very well handled"

- “She put the ‘care’ back in health care. She even called to follow-up. It’s nice to know she cared enough to inquire.” – Patient about their Transition Coordinator

- “I appreciated when my doctor from the hospital called me once I was home to let me know my pharmacy missed one of my medications. He re-sent my prescriptions to the pharmacy, so everything was set up for me, and I had all my meds when I went to pick them up the next day."

- “I left knowing what I was doing. Everything in my Plan of Care and My Story was explained to me. I had no questions for the team."

- “It was reassuring to know that the same people would continue seeing me anywhere in the hospital. I didn’t have to keep repeating myself.”
What we heard from physicians about their *Seamless Transitions* experience

**We support the process**
- Our patients are discharged sooner, discharges are smoother, and it’s easier to project discharge dates.
- We feel more comfortable with the planning process because of the enhanced post-hospital coordination (e.g. call family physicians to notify of patients’ discharges, fax prescriptions to pharmacies, etc.).
- We have more time to focus on medical issues - we spend less time answering questions specific to discharge process.
- The benefits of the Seamless Transitions approach for patients and practitioners far outweighs any inconvenience of learning a new process.
- Social work, physiotherapy, occupational therapy and the CCAC are engaged earlier in the process, benefitting the team and patients.

**Communication facilitates discharges**
- We have rounds more often, but it’s time well spent. The rounds are more focused, integrated and help us prioritize our patients differently.
- Rounds help us get a more complete picture of our patients. Changing rounds to the afternoon was an adjustment, but it’s working well.
- We get functional and psychosocial information from physiotherapy, occupational therapy and other allied sooner.
- The new rounds setup and constant communication with the team is helpful and appropriate, not overwhelming.

**We feel like part of the team**
- It’s easier to locate and talk with one physiotherapist and occupational therapist, versus several used in the unit-based model.
- It’s better that we are all working from the same patient list.
- We build relationships with our team members. We learn with and about one another.
- It’s fun being part of a group.
- It takes longer to get things done using the old model. There are more handovers.
- The only member of the standard care team missing is a pharmacist.

**Recommendations for spread**
- Physicians should be involved in recruitment for Transition Coordinators.
- Transition Coordinator role can be filled by individuals from a number of backgrounds (e.g. nursing, physiotherapy, occupational therapy, social work), but need to have experience working with Medicine program and hospital patients.
- Transition Coordinators should be linked to physicians, not to caseloads.
What we heard from hospital staff about their **Seamless Transitions** experience

**Feedback from Flow Coordinators**
- Enjoy collaborating with the Transition Coordinator
- *My Story* is helpful, but is sometimes hard to find on patients’ charts
- There is an opportunity to engage flow coordinators more for challenging patient cases, especially for help with communicating with families
- If approach is only being tested on certain physician teams, it would be helpful to have more reminders for unit staff about what physicians were testing what weeks to better identify “Seamless” patients - less support required for those patients

**Feedback from Emergency Department or QRP Nurses**
- Making sure we know that patients are being followed by the Seamless team from the beginning is very important
- Few *My Story* and Plan of Care documents brought back to the emergency department (ED) if patients had previously been admitted and seen by the Seamless team
- Opportunity for Transition Coordinators to connect with QRPs to alert of high-risk re-admits - potential resources to provide to patients in those situations that could lower risk of readmission
- Should better educate staff in ED about entire Seamless process

**Communication**
- More consistent, open communication between care team and patient/family - Transition Coordinator better ties everyone together
- Seamless team members were accessible
- *My Story* was helpful, especially contact information for community providers
- Problems consistently identifying patients in charts who were on Seamless caseload
- Some prefer information directly from Transition Coordinator, others prefer documented information

**Navigation**
- Patients seem to not feel so “lost” in the system - more coordinated approach to care planning
- Resources for discharge are established more firmly and quicker

**Efficiency**
- Everything is done before day of discharge (tightens load on charge and bedside nurses)
- “The moment the patient arrives in hospital, there is a plan.”
- Opportunity to address discharge barriers sooner, versus waiting until patient is medically stable
- Attending rounds is efficient and helpful
- Mobile PT/OTs see patients sooner compared to unit-based allied
- Easier to communicate with the CCAC

**Day of discharge**
- More organized
- Information is ready and easily provided to patients/family
- Charge nurses feel more comfortable telling patients things that will happen next - also feel patients seem more comfortable with the plan as well
- Discharges happen as planned
3.3 Quantitative measures

Patient Profile

September 29, 2014 to March 31, 2015

Our patients

- 319 total patients
- 51% female, average age = 72
- 49% male, average age = 70
- 34.7% of patients aged 80+
- 29% on CCAC services prior to admission

3.1% of patients readmitted with a related diagnosis (within 28 days)
8.6% of patients readmitted for any diagnosis (within 30 days)

Risk adjusted length of stay = 6.2 days (based on 279 patients)

Simple = 43%
Routine = 33%
Complex = 24%

Discharge destination

- Discharged home/home-like setting (home with support) 43%
- Discharged home (no home support) 33%
- Transferred to acute care inpatient (sub-acute, psychiatric, rehab) 2%
- Transferred to continuing care 13%
- Transferred to other facility (abulatory care, hospice, addiction centre, jail) 0%
- Left against medical advice 1%
- Died 8%

Top 3 CMGs:

- Stroke 7.1%
- Viral Pneumonia 6.3%
- Fluid/Electrolyte Imbalance 4.1%
Measures of success

The following synopsis provides some preliminary insights as to the impact of changes as well as provides a coherent story of the transformation. During the first 26 weeks (Sept. 29, 2014 to March 31, 2015) of testing, the Seamless team transitioned 319 patients out of hospital to home. The following analysis of known outcome measures – ALC rate and days, readmission rates, access and utilization of community services, length of stay – related to improved transitions was undertaken.

Summary of findings – what we learned

Patients moved through the health care continuum in a seamless, coordinated and planned fashion as evident by:

• Preliminary findings suggest that the 30 day readmission rates for any diagnosis are significantly lower for Seamless patients. In addition, 7 and 28 day readmission rate for related diagnosis is also much lower for Seamless patients. This implies that the new Seamless Transitions process enabled patients to transition home effectively with the appropriate bundle of community services and supports.
  – It is projected that the reduction in the readmission rate will save 0.9 bed days for every patient that goes through the Seamless Transitions process.
  – It is also anticipated that the rate of patient mortality will be reduced as readmissions increase the risk of death

• The Seamless Transitions process facilitated better identification of patients’ post-acute care needs. This led to a greater access and utilization of community services as more patients were discharged home with community support.

• Seamless patients did not have different outcomes than the Medical patient population with respect to: risk adjusted LOS. In addition, Seamless patients do not appear to have a lower LOS for either acute or ALC portion of hospital stay. The rate at which ALCs were declared for Seamless and other medical patients is similar; however, preliminary data indicate that there is not a significant difference in terms of ALC length of stay.
  – This may be the result of normal variation, confounding factors or that care processes are not yet sufficiently integrated in the program.

• A longitudinal analysis on Seamless patients would likely illustrate the benefits of an enhanced, coordinated approach to care on quality, cost and patient satisfaction.
Length of Stay (LOS)

Length of stay exploration provided a risk adjustment of the population. Atypical patients were excluded from the analysis:

- Deaths, transfers, sign outs and long stay patients (CIHI defined)
- This reduced the Seamless pool from 319 patients to 279, and the all Medicine patient pool to 2,679.

There was no noted difference between the Seamless group and the all patients group in regards to risk adjusted LOS. **The Seamless patients were discharged 0.4 days sooner than their expected LOS.** Of note, both groups average acute LOS is lower than the expected LOS, which may be an indication that during this time period, the hospital was efficient in discharging this patient population and there were likely limited or no addition efficiencies to be gained in this area during this time period.

Alternate Level of Care (ALC) Days and Rate

ALC analysis was completed on all Seamless patients (Sep 29th, 2014 - Mar 31st, 2015).

There is no significant difference in the rate at which ALCs are declared for Seamless and other Medicine patients. **Preliminary findings indicate that there is not a significant difference in ALC LOS for Seamless patients as compared to all Medicine patients (13.4 days vs. 14 days)**

Further analysis is required to determine the type of care ALC patients are waiting for (home, rehab, complex continuing care, retirement home, long term care etc.) to determine opportunities for future improvement aimed at reducing the ALC burden on the hospital.
DischargeDisposition

Discharge disposition analysis was completed on all Seamless patients (Sep 29th, 2014 - Mar 31st, 2015).

There was no difference in the percentage of patients discharge home for the Seamless and all Medicine patients (76% vs. 77%) group. Of highlight, a greater percentage of Seamless patients (16%) were discharged home with support. This suggests that the team was able to better identify patients post-hospital care needs and match these needs to community resources, which led to greater utilization of community services.

Readmissions

Readmissions analysis was completed on all Seamless patients (Sep 29th, 2014 - Mar 31st, 2015).

Note: For any given time period, readmission rates tend to increase over time. This occurs as patients who have been readmitted become discharged at a later date. The readmission rate among all Medicine and Family Practice patients for any diagnosis in a comparable period (October 1/14 – March 31/15) was 18.1%. This compares to a significantly lower readmission rate of 8.6% for Seamless patients. This reduction can be attributed to an improved transition planning process. Components such as providing a written individualized plan of care to patients/caregivers and community providers (including family doctors) or post-discharge calls likely impacted the readmission rate.
3.4 Process Measures

**Snapshot March**
An illustration of a portion of the data tracked to monitor performance and to learn and complete improvement cycles.

- **17 minutes** average length of rounds
- **17** Average number of patients discussed at rounds
- **12** Average number of patients on PT/OT caseload
- **19** Average number of patients on TC/MD caseload
- **47%** of patients discharged with CCAC services
- **5** Number of physicians who rotated through Seamless team
- **100** patients admitted
  - 40 Simple
  - 35 Routine
  - 25 Complex
- **78** patients transitioned from hospital to home
- **75%** of My Story care plans included in patients’ charts
- **89%** of discharge plans documented
3.5 Feedback from Design Team

“Having the allied health team work more closely with physicians has improved efficiency since we now have a consistent team wrapped around the patient. This enables us to have shared goals and helps us prioritize which patients to see based on the established discharge plan. The transition pathways and constant communication with care team members helps us determine patients who need our resources the most.” – Dr. Terence Tang, THP-CVH

“A side benefit of the Seamless Transitions approach is that beyond improving transitions for patients, we are also improving transitions for physician caseloads. It can be stressful in the first few days of a new rotation, trying to gather all the information about a new patient caseload. With Seamless Transitions, now we have an entire team following the patient already and we can much more quickly get up to speed on what’s been happening with our patients.” – Dr. Vipan Nikore, THP-CVH

“The biggest thing I noticed is that because we are a dedicated team working towards the same goals (the hospital, CCAC, patient), communication is better.” – Suzanne Nevers, THP-CVH, Physiotherapist

“I believe patients feel more reassured that a consistent team will be with them through their stay. Connecting with CCAC earlier moves discharges along faster. We are able to identify barriers and challenges earlier on in their admission.” – Janet Moorehead, THP-CVH, Occupational Therapist

“Patients are more confident leaving hospital, knowing they’ll continue to be supported at home. I’ve also seen better communication and collaboration amongst the care team. Together, we are able to plan for meaningful discharges for patients.” – Tracey-Anne Hasfal, Mississauga Halton CCAC and TC, Care Coordinator

“I’m excited that consistent, high quality practices are being better engrained into our transition planning process. We are connecting more with patients, building relationships, and helping them feel like they will have what they need to manage their health after leaving hospital.” – Germaine Subnaik, Patient Navigator and TC, THP- M-site

“It’s been eye opening to see that the community and the hospital have very similar problems – we face the same barriers when trying to plan transitions from hospital to home for patients. With the Seamless Transitions team, we are communicating with the entire care team from the hospital, CCAC and community. This has helped us execute discharges more quickly and more effectively.” – Irina Kasianik, Social Worker and TC, THP-CVH
3.6 Lessons learned and observations

- Need to allow for time and the opportunity to build trusting relationships and develop a shared understanding between participating organizations.

- Need to break down jurisdictional barriers to increase chances of success.

- Imperative to build a shared organizational culture to facilitate work across sectors (hospital and community).

- Committed and courageous leadership is required to support transformational change.

- Operational leads and supports must be identified and engaged in a structured way from the beginning.

- It is important to keep the patient at the centre of the process and utilize partnership principles to keep work focused.

- Continued engagement of stakeholders is necessary to maintain momentum.

- Innovative change requires new attitudes and behaviors from each member of the care team: the patient, the family, the physician, hospital staff and community staff. Changing culture is challenging and requires time and continuous effort.

- Performance monitoring is vital to ensure staff/teams maintain new processes and do not inadvertently revert back to “old way” of practicing.
Section 4

Implementing the *Seamless Transitions* approach
4.1 Implementing to Scale

The goal of this step is to move the successfully tested Seamless Transitions approach from pilot to implementation by replicating the changes in other parts of the organization or within other organizations.

Transitioning Phase: From test to implementation

Testing a change on a small scale, while learning and honing through several PDSA cycles, defines the change for implementation on a broader scale. Implementation is a permanent change to the way work is done and requires building for preparedness to successfully bring the change into the organization. During the transition phase, it is paramount to support individual skill development and team building within and across organizations. Operational changes such as management structure, role definitions, job postings, interviews and a realignment of policies and procedures are required. Technology changes need to be leveraged and a communication plan must be rolled out. The purpose of the transitioning phase is to ensure stakeholders are prepared and engaged before the shift from the “old way” to the “new way” of operating occurs.

Remember:
Implementation is a process, not an event. It may take months to fully implement the ideal design.
4.2 Transition and Implementation Phases: Overview

Purpose:
- To make a permanent change to the “new way” of doing things.
- To provide a structured approach to sharing and educating staff about the change concepts and processes.

Objectives:
- Develop and document a detailed implementation plan, including timelines, target area and communication strategies.
- Outline resources required for implementation, ongoing monitoring and sustainability.
- Align policies, procedures, roles and responsibilities to support Seamless Transitions practices.
- Identify and monitor metrics to ensure implementation is occurring as planned, and the expected outcomes are achieved.

Implementation activities:
- Ensure key stakeholders are on board
- Develop and implement a communication plan re: outcomes of test phase and rationale for implementation.
- Establish outcomes, process and balancing measures to be tracked.
- Establish an education plan for frontline staff at all impacted organizations.
- Roll out training and education to staff.
- Establish ongoing communication plan for feedback and continued learning.
- Develop a process for continuous improvement.

Outcomes and deliverables:
- Change concepts are implemented in target area(s).
- Change concepts become standard operating procedure.
- Affected policies, procedures, roles and responsibilities are updated to support the Seamless Transitions processes.
- Processes are in place for systematic monitoring of outcomes, process and balancing metrics.
- Accountabilities related to metrics are in place across organizations.
A number of guiding principles related to **process, people** and **structure** will enable smooth transitioning from test/pilot to full implementation. For this stage to occur, it is expected that enough information has been gathered to make an informed decision with regard to spreading change concepts. The following guiding questions will support this decision-making process.


- What are the specific change concepts you are spreading?
- Where will the change concepts be implemented?
- When will the change concepts be initiated?
- What resources and materials will be required and how will they be implemented?
- Which metrics will be tracked, how and by whom?
- What are the identified accountabilities and how will they be reviewed?
- What is the communication plan and who is leading it?

- **What are the specific change concepts you are spreading?**

Decide whether you want to spread elements of the new approach or the process in its entirety. It is important to consider the interdependencies of the components as this may impact the ability to implement selected components. While implementing elements of the process, associated tools and documents may support efficiencies in current processes. Innovative change requires implementation of the entire process to realize the outcomes measured during test and achieve the desired cultural shift.

Listed below are the seven components of **Seamless Transitions**.

1. Integrated mobile care team
2. Enhanced care coordination – Transition Coordinator (TC) role who links directly with community providers
3. Transition planning starting on admission, in the ED as required
4. Comprehensive, individualized written transition plan – *My Story* and *Plan of Care* for patients, caregivers and providers
5. Brief, discharge-focused rounds
6. Timely post-discharge follow-up calls and/or visits to ensure follow through on transition plan has occurred
7. Timely, accurate information flow - from patients/families and community providers ↔ amongst hospital teams ↔ back to patients/families and community providers to avoid gaps in care.

**Recommendation: Implement all seven key components.**
• Where will the change concept be implemented?
Readiness for change, impact of change, and supportive engagement from administrative (support) and medical leaders at all levels must all be considered when deciding to implement change, whether it is on a small or large scale, to ensure success.

   Recommendation: Implement across the Medicine program at THP – CVH site.

• When will the change concept be implemented?
Once the decision is made to spread, the change operational leaders across both organizations must collaborative to determine an appropriate implementation date and timeframe to make the change.

   Recommendation: Implement sooner rather than later. Delaying the implementation long after test phase completion will diminish momentum generated during initial phases of the initiative.

• What resources and materials will be required and how will they be implemented?
Resources needed for implementing a new approach will vary from program to program or hospital to hospital depending on the size and scope of the implementation, as well as ultimate goals. To determine resources required to implement all of the key components of the Seamless Transitions approach across a program follow the steps outlined. Step 1 - obtain utilization data to determine how beds in program. Step 2 - utilize optimal team mix to determine staffing resources required and number of teams. Step 3 - calculate cost.

   For example, assumptions:
   • 120 patients
   • Optimal care team mix (one team): 1 MD, 1 SW/Discharge Planner, 0.5 CCAC CC, 0.5 PT, and 0.5 OT. (Six teams require 6 MDs, 6 SWs/Discharge Planners, 3 CCAC Care coordinators, 3 PTs and 3 OTs)
   • Six teams
Notes (based on test):

- Projected caseload: MD 1: 20, SW 1:20, OT 1:40 & PT 1:40 (cover 40 patients each however only those patients referred by the team or MD are seen. The average of 12 patients seen daily during test phase is a full caseload) and CCAC care coordinator 1:40 (cover 40 patients however only need to see patients streamed as routine or complex based as per post-acute care needs).

- Teams have the ability to flex and can efficiently and safely care for additional patients depending on the case mix.

- The teams’ caseloads are driven by the MRP caseload and will vary based on demand. During the test phase, the team caseload ranged from 14 to 26 patients. Managing a caseload above 25 was challenging and not sustainable because the team members’ ability to engage fully in processes was noticeably reduced.

- Adding another team will require the addition of another physician as well as 1 SW, 0.5 PT, 0.5 OT and 0.5 CCAC care coordinator.

- The team can follow patients admitted to off-service areas.

- The team works collaboratively with the broader unit-based interprofessional team in caring for patients.

- Consideration must be given to the need for all team members to have access to Blackberries for immediate communication.

- Materials to hold the patient’s transition package, including business cards, are required.

Recommendation: 1) Implement Seamless approach – five-day per week model initially, while exploring the feasibility for moving to a model with backfill.

2) Tablets or computer on wheels for Transition Coordinators (CCAC care coordinators already use tablets).
What metrics will be tracked, how and by whom?

In order for process improvement changes to become sustainable and imbedded within an organization, performance management is critical. It is necessary to establish a core set of agreed-upon mandatory metrics that teams are required to monitor. By providing teams with daily “real-time” feedback, team members are better able to understand root causes of challenges and adapt and refine processes immediately. Visual triggers quickly identify which metrics are meeting targets and short-term patterns are identified. During the test phase, a number of metrics were tracked daily and reviewed during weekly team huddles to identify target variances, predict challenges in work flow, identify the impact of extenuating circumstances, understand staffing requirements and identify process improvement opportunities.

Examples of team KPIs:
- All patients seen and assessed within 24 hours of admission.
- Initial discharge plan identified within 24 hours of admission.
- Percentage of patients discharged on identified expected discharge date.
- Percentage of patients that received a post discharge phone call within established time-frame.
- Percentage of patients that receive an OT or a PT assessment on the date of referral.
- Time from initiation to completion of RAI assessment by CCAC for LTC.

Examples of program/organizational KPIs:
- Patient satisfaction
- Average length of stay (acute as well as ALC)
- Readmission rates in several categories (with CCAC services, with similar diagnosis, without family physicians, etc.)
- Alternate Level of Care (ALC) days and rates

During the test phase, the process measures were tracked manually; this was labour intensive and time consuming. Opportunities to automate this process should be explored. In addition, a dedicated decision support staff should be identified to enable completion of this work throughout the test phase.

**Recommendation:** 1) **Build a framework of performance metrics that can be cascaded throughout the organizations. Establish goals, decide on measures (KPIs), establish baselines then set meaningful targets.**

2) **Create an electronic dashboard/scorecard to monitor team, program and organizational performance (will require data sharing across organizations).**
• What are the identified accountabilities and how will they be reviewed?

It is essential to establish clear accountability for performance. To achieve this, there must be clearly defined roles and responsibilities with regard to transition planning for each member of the team. Identify which team member will be responsible for each task and outline clear expectations for accountability, even though there may be overlap in some tasks. It is also important to be aware of the impact of the environment and access to technology on the efficiency to complete tasks. This can be attained by standardizing work processes. Three standard elements addressed in the test phase were:

1. Expected time it takes to complete a given task (e.g. My Story baseline assessment)
2. Sequence for the work to be completed (e.g. My Story completed before daily discharge planning rounds)
3. Standard tools/resources that are required to keep the process operating smoothly (e.g. access to phones and fax machines, access to physician lists via MediTech)

(See Toolkit for standard work for all team members and proposed job description for Transition Coordinator.)

Once performance and value expectations are established an accountability system must be put into place to hold staff and leaders accountable for performance.

Recommendations: 1) Establish a memorandum of understanding (MOU) that defines the shared accountability structure

2) Establish a structure that allows for daily information flow and regular performance huddles and review meetings at all levels across both organizations.

3) Identify and confirm leaders across both organizations that will be responsible for performance management.

• What is the communication plan and who is leading it?

Program directors and managers and charge nurses must be informed of the plan to implement the Seamless Transitions approach and why it is important and relevant to patient-centeredness, as well as everyone’s daily work. Assumptions will need to be vetted. Inform staff at focused meetings and through posters in common rooms about the changes to the transition planning processes and provide education sessions and training opportunities, such as job shadowing, to promote awareness and understanding. Engage physician leads to communicate changes in the physician’s role to their physician colleague group. Ensure consistent messaging is shared to hospital, CCAC and service provider staff, developed in tandem by communicators from each respective organization, weighing work culture factors that influence receptiveness to messaging.
Recommendation: Identify a communication lead to work collaboratively with the project/change manager to craft key messages and ensure consistency of organizational communications, ideally leveraging the lead who was identified during the test phase.

Guiding Questions: Process, People, Structure

- Who is the Spread Leader? Who is the Senior Lead(s) and Executive Sponsor(s) and how will they be present throughout the process?
- Who are the key stakeholders in each part of the roll-out and who will oversee each part of the project?
- Who will schedule and provide staff and MD education?
- Who will provide initial and ongoing support to maintain processes and support change management? Who will provide initial material resources?

- **Who is the Spread Leader? Who is the Senior Lead(s) and Executive Sponsor(s) and how will they be present throughout the process?**
  The Spread Leader must be conversant with the principles of change management and understand that processes and roles are undergoing change as are the people. They must have the flexibility to step back and let processes and people learn the new approach and how to work together within the new model. They must let the teams work through and overcome initial challenges associated with learning a new process, providing support as necessary. The Spread Leader must be fully engaged in the process, be able to build capacity for full implementation and be comfortable to provide feedback to all team members about their performance under the new model.

The spread leader is responsible for:

- Recruiting the implementation team
- Identifying process owners and change champions
- Getting buy-in of hospital and CCAC staff
- Creating an implementation plan
- Building skills to support and sustain improvement
- Troubleshooting as the processes is rolled out."
• Monitoring and reporting progress on key measures and providing feedback.
• Monitoring sustainability

It must be clear to staff and physicians that there is clear buy-in from Senior Leadership regarding the Seamless Transitions process and its positive benefits for patient care, as well as for the work environment.

**Recommendation: Appoint a Spread Leader who is knowledgeable of the new process and the change implications as it relates to existing hospital and CCAC operations.**

• **Who are the key stakeholders in each part of the roll-out?**

  **Internal**
  - Hospital leadership: SLC, PSC (Program and Medical Directors), Leadership Forum
  - Medicine Program (leadership, staff and physicians)
  - Hospital: all staff and all physicians
  - CCAC leadership: EC, Patient Care Leadership Forum
  - CCAC – Patient Care staff
  - CCAC – all other staff
  - MH LHIN
  - Board of Directors (for both organizations and the LHIN)

  **External**
  - Patients
  - Family/ caregivers
  - Community providers
  - Primary Care physicians
  - Pharmacies
**Recommendation:** Targeted, top-down communications about change implementation plan with each stakeholder group, using consistent key messaging developed by communications and change management leads from both organizations

- **Who will schedule and provide staff and MD education?**

  In addition to the organizational and leadership drivers outlined above, competency drivers are another common feature of successful implementation and maintenance of new processes. Competency drivers include selecting, training and coaching those delivering the new processes. Staff members who were engaged in the test phase of *Seamless Transitions* should be leveraged at this stage. They are also an excellent resource for “train-the-trainer” sessions that will promote learning from peers in a small group environment, and can help identify situations or challenges that may not be inherent to current processes, but require due consideration. Facilitators should be respected by their colleagues and model the behaviors being asked of them. The core content for each session and the number of sessions must be defined. The timing and location of training sessions must support engagement. By following training with coaching, it enables learning to be better incorporated into practice the way it was intended.

  A variety of education forums may be utilized to educate staff.
  - Staff orientation - include an introduction to policies and procedures related to transition planning
  - On-the-job learning – this may be included as part of the onboarding process
  - A mentorship program – more senior staff (who have been trained in transition planning) provides education and support to more junior staff
  - In-services – a less formal learning opportunity for staff
  - Staff forums – can be unit based on hospital-wide
  - Self-directed learning

  **Tips for educating staff:**
  - Identify the target audience
  - Identify their learning needs
  - Determine the education goals, objective and outcomes
  - Use principles of adult education when developing the education plan
  - Select a format for the education presentation
  - Decide on the expected outcomes of the education program
  - Measure the effectiveness of the education program
Recommendation: 1) Operate and utilize the two teams that were established during the test phase as a learning hub. Staff (hospital and CCAC) can rotate into the teams to gain experience (learning by doing), as well as receive education and coaching from experienced team members on the new Seamless Transitions processes prior to implementation.

2) Engage and leverage educators, professional practice leaders and learning specialists to work collaboratively with staff members who were engaged in the design and test phase to develop a comprehensive training and education program. This program should focus on training and education on the process, as well as competencies needed for forming and sustaining high performance teams.

- Who will provide initial and ongoing support to maintain processes and support change management? Who will provide initial material resources?

The Discharge Planning Manager and CCAC Hospital Manager will collaborate to support ongoing management of individuals from both organizations as the process rolls out. Their focus will be on operationalizing the new approach across the Medicine program, liaising with the Spread Leader to facilitate education and performance management and communicating key messages to staff about the change. Communications specialists and change management experts from both organizations will support the rollout of the approach.

Recommendation: Implement joint operational leadership from hospital and CCAC as the scope of the new approach spans both sectors.

Guiding Questions: Process, People, Structure
- Policies and procedures in place?
- Governance structure in place?
- Project reviews and timelines confirmed?

- Policies and procedures in place?
Consider reviewing/revising the policies and procedures that dictate transition planning practices for hospital and community staff. These policies and procedures should be updated to reflect the process changes brought about by the new Seamless approach to transition planning. Examples of policies include:

- Discharge policy
- Patient refusal to leave hospital policy
- ALC policy, including ALC-LTC process
- Escalation policy
- Admission policy

It is imperative that the appropriate policies and procedures are in place as they will be required for education/utilization during onboarding. These policies and procedures should be included in a manual or toolkit that is readily available for reference by care teams and/or educator (at the hospital) and learning specialist (at the CCAC).

Furthermore, integrated policies and procedures help ensure a consistent and systematic understanding of the roles and responsibilities of staff (hospital and CCAC) involved in the assessment and transition planning process. When policies and procedures are in place, it is more likely that services will be coordinated to best meet the individual needs of the patients receiving care. Protocols are also more likely to provide a solid basis for hospital and CCAC staff to work together to deliver effective integration along the continuum of care.

**Recommendation:**
1) Update discharge policies and procedures to incorporate new ways of working and to reflect amended, integrated transition planning processes.

2) Using similar language in both THP and CCAC policies to promote common understanding and improved communication.

- **Governance Structure in place?**

Implementation is not an individual endeavour. A team of individuals should be assembled as a steering committee to formulate and work through the implementation process. The team can be composed of stakeholders and others who have a vested interest in improving outcomes for patient care. There should be a documented and approved governance structure in place to guide the implementation phase and to review and guide key deliverables.
Recommendation: Establish an integrated leadership team, comprised of individuals from hospital and CCAC, who will be responsible for providing guidance throughout the transition and implementation phases.

- Project review and timelines confirmed?
  During the test phase, the team met on a weekly basis to review processes, identify challenges and to share new learnings. This is an important part of team building. During implementation, similar team meetings must be scheduled (weekly at first and then bi-weekly and at a minimum monthly) to review metrics and discuss potential changes and impacts of other projects. These meetings should be chaired by the Spread Leader. New teams should be given a “go-live” date so all other hospital and community providers are aware of who the contacts are for their patients. There should also be a set timeline for implementation completion for the current expansion across the Medicine program at CVH before the Seamless Transitions process is spread to another unit or program.

Key activities for implementation
- Ensure key stakeholders are on board
- Develop and implement communications plan re: outcomes of test phase and rationale for implementation
- Establish outcome, process and balancing measures to be tracked
- Establish an education plan for frontline staff
- Roll-out training and education to staff
- Establish ongoing communications plan for feedback and continued learning
- Develop a process for continuous improvement

Recommendation: Once key activities are completed and deliverables are achieved, spread action can begin; determining the date of implementation before change management process begins will be key to maintaining momentum and successful implementation, endorsed by all stakeholders
4.3 Change Management Approach

Unfreeze – Strategies used to motivation to change

Throughout the initiative’s define and brainstorming phases, multiple frontline staff from the hospital and community, as well as patients and caregivers in the region, were engaged as real experts to provide feedback on their experiences with transition planning. Key stakeholders at all levels, both internal and external, were identified to support change. The right individuals were selected to participate in the various phases of change. Staff who are flexible and open to change and feedback were selected to champion the work, acting as members of the dedicated Design Team. The original Design Team was divided into clinical and evaluation teams. The clinical team was responsible for testing the new processes and the evaluation team was responsible for monitoring the impact.

The change was introduced on a small scale to minimize disruption to current operations and patient care. Initially tested with one team, the test was expanded to a second team over time as workable caseloads were established. The mandate of transformation innovation was highlighted, leading to the creation of an evocative problem statement to guide the Design Team’s work. Patient centeredness remained at the core of all discussions. In identifying gaps and duplications within the current processes, many myths were dispelled and information gaps identified.

A culture of open, blameless communication was established for process and outcome expectations, feedback and role clarification. Communication strategies included weekly huddles open to all stakeholders, 1:1 meetings with managers (Medicine units, flow, CCAC), attendance at Medicine unit huddles, presentations to staff, newsletter updates, intranet pages for THP and CCAC and a joint town hall.

Unfreeze
- Creating the motivation to change

Design and Test
- Stabilize new approach

Change
- Spread the Change
- Making change permanent

Refreeze
Strategies for stabilizing the new approach

- Develop standard work for all team members and create a document that outlines the standard work/expectations of all team members.
- Develop new behaviour, values and attitudes for staff and management.
- Performance management is vital. Need: 1) to establish process for monitoring and evaluating process change and 2) team based performance management that is outcome based.
  - Information is necessary to support decision-making and operations, clinical care and service delivery; determine where and how to improve quality and overall performance, and support accountability reporting. This information needs to be relevant, valid, reliable and accurate. It needs to be fairly interpreted and reported, understandable and useful. Partners also need to commit to collecting and sharing high-quality, comparable information on essential aspects of health system performance.

Strategies for refreezing – making change permanent

- Utilize Design Team members as change agents.
  - These members represent various professional groups (e.g. physicians and direct care providers) who are motivated team members who can educate their respective professional groups and advocate for the changes Seamless Transitions will bring. They are also the representatives and advocates of their respective groups within the implementation team. Change agents are also tasked with moving from test/pilot to implement, and ultimately sustaining changes and improvements created from the initiative.
- Identify a change leader.
- Show value added changes to facilitate sustained adoption of processes.

**Remember:**
Any change, even if it is positive, brings anxiety, and people often respond by resisting the change and trying to return to the familiar.
4.4 Conclusion and future directions

As evident from the literature and as observed during the Seamless Transitions initiative, discharge from a hospital can be a complex process. It is not a one-time event, and no single act will make it work better. Transition from hospital to home involves care coordination among hospital staff; between hospital staff, the patient, and family; between hospital staff and community providers; and between the patient, family, and community providers. As such, an integrated approach to the planning and delivery of services is required to ensure continuity across organisational boundaries and a smooth transition for patients from acute care back to the community. Although there has been considerable progress, prior to and most recently with the Seamless Transitions initiative, there are still opportunities for further improvement in transition processes.

Recommendations for future consideration:

Leadership:
- Establish a joined operational leadership team to provide oversight for future transition planning work and who will be responsible to ensure ongoing performance monitoring and management of the new process within and between participating organizations.
- Leverage the Discharge Planner Manager role; this role could be jointly appointed by the hospital and CCAC and the position spans these two settings, managing the transition process from both perspectives. This involves oversight of the integrated work between acute and community staff, trying to increasing the level of integration and involvement in process and policy development to improve discharge and transfers of care between hospital and community.

Technology:
- Utilization of information technology to support and improve efficiency of the Seamless process, for example, electronic tool – My Story and Plan of Care.
- Automated process for inputting, tracking and measuring outcome data.

Roles:
- Once the Seamless Transitions process has been fully implemented and is stable, test the integrated Transition Coordinator role. This will require training and special access to cross-system information.

Patients expect and have a right to seamless and coordinated transition from one part of the health care system to another. They have little concern for differences in funding and organizational structures. For many patients, continuing care is provided by health care providers in the community and the term ‘transition’ is therefore used to denote the requirement for continuity of care from hospital to home. Having one title for the same roles and responsibilities of transition planning, whether in hospital or in the community, supports the concept of integrated and patient-centered care.
Other options to test

- Integrated Transition Coordinator role
- Coverage on weekends and holidays for the entire team
- Further engagement of community providers – such as increased primary care physician involvement in the transition process
- Technology enablers – such as electronic forms/documents
Section 5

Toolkit
5.1 Purpose of the Toolkit

This document includes tools to promote standardization in transitional care practices, including roles, responsibilities, job descriptions and key activities (standard work) for each integrated care team member as defined within the new Seamless Transitions approach.

This toolkit should be used to facilitate the adoption of a consistent approach to transitional care planning. It complements the Seamless Transitions: Hospital to Home Guide, which outlines key components, learnings and results from all stages of the initiative’s design and test phases, as well as recommendations for spread.

The proposed components and processes in this toolkit build on best practice evidence and experience, as well as input from patients, families and hospital and community providers.

**Integrated care team**

1.1 Integrated care team – roles and responsibilities

1.2 Key activities (standard work) for integrated care team

1.3 Physician welcome letter

1.4 Core competencies for Transition Coordinator (Social Worker/DCP/Care Coordinator)

1.5 Job description for Transition Coordinator (Social Worker/DCP/Care Coordinator)

**Resources to facilitate transition planning process**

**Transition planning tools used at admission**

2.1A – How to obtain a patient list from MediTech

2.1B – Sample script for transition coordinator introduction to patient

2.1C – Transition Pathway criteria

2.1D – My Story (baseline assessment initiated within 24 hours of admission)
Transition planning tools used during hospital stay

3.2A – *Plan of Care* – Simple patients (for providers)
3.2B – *Plan of Care* – Routine and complex patients (for providers)
3.2C – *My Care Guide* (for patients)
3.2D – How to facilitate discharge rounds (SPAMM model)
3.2E – Frequent topics of conversations with patients and families
3.2F – Teach back methodology
3.2G – How to facilitate a family meeting or case conference

Transition planning tools used at discharge and during follow-up

3.3A – Discharge checklist
3.3B – Script for post-discharge phone calls
1.1 Integrated care team – roles & responsibilities

Delivering patient-centered care using a team-based approach required significant changes in how work is distributed. These changes required the development of new levels of trust and communication among staff (hospital and CCAC) and physicians. Improving efficiency and increasing satisfaction amongst patient, staff and physician required redefining teams, job descriptions, performance expectations and a change in relationships.

The integrated care team is an interprofessional team comprising of a TC (SW/DCP), TC (CCAC CC), occupational therapist, physiotherapist and a physician. This team provides a more thorough assessment than a single discipline could achieve. They work collaboratively to develop a single individualized post-acute plan of care which includes a transition plan. As such, the team is responsible for taking a more pro-active approach to transition planning. The Seamless Transitions discharge coordination model involves coordinating care across the continuum but does not deal with clinical care.

**Principle of team-based care**

<table>
<thead>
<tr>
<th>Shared goals</th>
<th>The team—including the patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient needs, and can be clearly articulated, understood, and supported by all team members.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear roles</td>
<td>There are clear expectations for each team member’s functions, responsibilities, and accountabilities, which optimize the team’s efficiency making it possible for the team to take advantage of division of work, thereby accomplishing more than the sum of its parts.</td>
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<tr>
<td>Mutual trust</td>
<td>Team members earn each other’s trust, creating strong norms of reciprocity and greater opportunities for shared achievement.</td>
</tr>
<tr>
<td>Effective communication</td>
<td>The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members.</td>
</tr>
<tr>
<td>Measurable processes and outcomes</td>
<td>The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team’s goals. These are used to track and improve performance immediately and over time.</td>
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</table>
The TC (SW/DCP) and the TC (CCAC CC) function as a dyad. In this dyad, a CCAC care coordinator and a THP social worker/patient navigator working in tandem to perform the necessary standard work/task to plan for transition home. The dyad utilizes a case management model where patients are reviewed on admission and then assigned to a TC caseload (SW/DCP or CC) based on presentation and anticipated post-acute care needs. As such, the TC shares the caseload and their role is one of a case manager where they are responsible for assessing, planning, implementing, coordinating, monitoring and devaluing options and services to meet the patient health needs through communication and available resources to promote and deliver quality care.

The role of the Transition Coordinator (SW/DCP or CCAC CC) is to:

- Undertake or coordinate a detailed assessment of the patient, their premorbid function and social status
- Develop a transition plan in consultation with the patient, family and care team
- Ensure patients receive care in the most appropriate place for their health needs
- Provide consultation services to hospital staff, which includes providing expertise on the availability of community services and resources to meet the patients post-acute care needs
- Liaise with community services to improve patient access to health services
- Promote the hospital and CCAC transition policies and practices and assist staff to understand and comply with the transition process
- Promote a transition planning focus during patient care discussions

(Adapted from: Improving patient transitions from hospital to community: a good practice guide)

The following standard work outlines the responsibilities of the team members.
### 1.2 Key activities (standard work) for integrated care team

**1) Transition Coordinator (Social Worker/DCP/Care Coordinator) – Getting started (ALL patients)**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
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</thead>
</table>
| **Identifying your patients** | Obtain patient list from MediTech hospitalist census (see Appendix 3.1A for instructions)  
Review patient information:  
- MediTech: consults, tests, orders for OT and PT, any previous social work notes  
- CHRIS: If patients currently on CCAC services review notes to obtain information to help build *My Story* (patient profile). Contact their CCAC care coordinator to notify them of admission and obtain information that will help establish patient’s baseline. Place services on hold in CHRIS, send notification to service providers, document in CHRIS notes and notify community care coordinator that patient is admitted to hospital and services are on hold. |
| **Meeting your patient** | Review chart on the unit – progress notes, doctor’s orders, MedRec (for pharmacy and family doctor contact info), ER triage assessment  
Visit patient – either in ED or on unit  
Introduce yourself – name, role, the physician you’re working with and explain how you would work with them and their family to coordinate the care they need to transition home  
Obtain information to initiate and complete *My Story* within 24 hours of admission (See Appendix 3.1D for example of *My Story*)  
Confirm information obtained from MedRec and CHRIS - review materials in step one (e.g. contact information for family physicians, emergency contacts, previous hospitalizations)  
Contact family physician’s office:  
- Notify them of patient’s admission. Obtain information about patient’s status prior to admission, as necessary. Inform family physician you will provide them with plan of care and prescriptions upon patient’s discharge  
- Inform family physician you will set up follow-up appointments (as appropriate) for patient  
If patient does not have a family physician:  
- If patient agreeable, contact the patient’s local CCAC and ask to speak to a Health Care Connect Nurse who will be able to find a physician for the patient. |
| **Choosing a Transition Pathway** | Stream your patient based on post-acute care coordination needs  
- After completing *My Story*, stream your patient into the appropriate pathway – **Simple/Routine/Complex** (See Appendix 3.1C for criteria) |
1A) Transition Coordinator (Social Worker/ DCP/ Care Coordinator) – Caring for SIMPLE patients

After you have completed steps one and two, and have determined your patient transition as SIMPLE (requires no post-acute care services in the community), follow the steps below to prepare your patient for transition from hospital to home.

<table>
<thead>
<tr>
<th>4. During hospital stay</th>
<th>Review patient chart and MediTech profiles daily</th>
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<tbody>
<tr>
<td></td>
<td>Visit patient daily – planning for discharge, building Plan of Care (see Appendix 3.2A for sample Plan of Care)</td>
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<tr>
<td></td>
<td>• Answer patient/family questions and address concerns or worries. Review Plan of Care (See Appendix 3.2E for frequent topics discussed with patients and families)</td>
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<td></td>
<td>• Review Plan of Care with patient/family</td>
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<td></td>
<td>• Identify patients who may benefit from bedside rounds, family meeting and/or care conference</td>
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<tr>
<td></td>
<td>Check doctor’s orders to ensure patient is progressing based on care plan</td>
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<td></td>
<td>Check in with charge nurse, flow nurse and primary nurse – review patient’s status and plan and address any barriers to discharge</td>
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<td></td>
<td>Identify other members of the integrated care team that will be involved in planning for discharge – share names with patient and explain each member’s role (will vary based on patient needs)</td>
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<tr>
<td></td>
<td>Participate in team (table) rounds daily in afternoon (See Appendix 3.2D for procedure to conduct team rounds)</td>
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<tr>
<td></td>
<td>• Participants include: Physician, TC, PT, OT, charge nurse, flow and other identified members of the broader care team</td>
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<tr>
<td></td>
<td>• Review discharge plan (i.e. targeted discharge dates, discharge destination, barriers to discharge, etc.)</td>
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<td></td>
<td>Set up and facilitate family meetings and team meetings (includes extended team)</td>
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<td></td>
<td>Coordinate health teaching for patients and families about diagnoses, medications, what to look for when they’re home, future health care planning etc.</td>
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</table>
5. At discharge:

- Notify family physician of discharge (as soon as discharge date is confirmed)
- Fax *Plan of Care* and prescriptions to family physician
- Fax prescription to pharmacy – phone pharmacy to confirm fax number prior to faxing
- Remind patient you will be conducting a follow-up phone call *(within 24-48 hours)* (see Appendix 3.3B for post-discharge phone call script)

1B) Transition Coordinator (Social Worker/ DCP/ Care Coordinator) – Caring for ROUTINE and COMPLEX patients

After you have completed steps one and two from above, and have determined your patient transition as COMPLEX (requires more than one post-acute care services in the community); you follow the steps below to prepare your patient for transition from hospital to home.

4. During hospital stay

- Review patient chart and MediTech profiles daily
- Visit patient daily – planning for discharge, building *Plan of Care*
  - Answer patient/family questions and address concerns or worries. Review *Plan of Care* (See Appendix 3.2E for frequent topics discussed with patients and families)
  - Review *Plan of Care* with patient/family
  - Identify patients who may benefit from bedside rounds, family meeting and/or care conference
- Check doctor’s orders to ensure patient is progressing based on care plan
- Check in with charge nurse, flow nurse and primary nurse – review patient’s status and plan and address any barriers to discharge
- Identify other members of the integrated care team that will be involved in planning for discharge – share names with patient and explain each member’s role (will vary based on patient needs)
- Participate in team (table) rounds daily in afternoon (See Appendix for procedure to conduct team rounds)
  - Participants include: Physician, TC, PT, OT, charge nurse, flow and other identified members of the broader care team
  - Review discharge plan (i.e. targeted discharge dates, discharge destination, barriers to
<table>
<thead>
<tr>
<th><strong>5. At discharge:</strong></th>
<th><strong>Working with physicians and pharmacists</strong></th>
</tr>
</thead>
</table>
| □ Notify family physician of discharge (as soon as discharge date is confirmed)  
  - Fax *Plan of Care* and prescriptions—phone pharmacy to confirm fax number prior to faxing  | |
| □ Fax prescriptions to patient’s pharmacy | |
| **Working with community providers** | |
| □ Contact CCAC community care coordinator – let them know patient is being discharged and will be coming back on CCAC care  
  - Scan *Plan of Care* into CHRIS and share *Plan of Care* with community CCAC care coordinator  | |
<p>| □ Share <em>Plan of Care</em> with patient’s community service providers (sent by CCAC Team Assistant) | |
| □ Confirm delivery of equipment and supplies (if required) – confirm day/time of delivery and service provider visits | |
| □ Conduct post-discharge case conferences (as needed) with CCAC and community service providers | |
| <strong>Working with patients and families</strong> | |
| □ Provide resources needed for post-acute care to the patient (including <em>My Story, Plan of Care,</em> community resources and clinical education materials) | |
| □ Provide contact information for service provider and care coordinator – explain the difference between patient’s CCAC community care coordinator and service provider | |
| □ Remind patient you will be conducting a follow-up phone call (within 4-7 days) | |
| □ Emphasize importance to patients of bringing personalized <em>My Story</em> and Plan of Care to all follow-up appointments and back to hospital if readmitted | |</p>
<table>
<thead>
<tr>
<th>Box</th>
<th>Task</th>
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<tbody>
<tr>
<td>□</td>
<td>Conduct post-discharge visit to patient’s home (if needed)</td>
</tr>
</tbody>
</table>

**Working with physicians and pharmacists**
- □ Notify family physician of discharge (as soon as discharge date is confirmed)
  - Fax *Plan of Care* and prescriptions—phone pharmacy to confirm fax number prior to faxing
- □ Fax prescriptions to patient’s pharmacy

**Working with community providers**
- □ Contact CCAC community care coordinator – let them know patient is being discharged and will be coming back on CCAC care
  - □ Scan *Plan of Care* into CHRIS and share *Plan of Care* with community CCAC care coordinator
- □ Share Plan of Care with patient’s community service providers (sent by CCAC Team Assistant)
- □ Confirm delivery of equipment and supplies (if required) – confirm day/time of delivery and service provider visits
- □ Conduct post-discharge case conferences (as needed) with CCAC and community service providers

**Working with patients and families**
- □ Provide resources needed for post-acute care to the patient (including *My Story, Plan of Care,* community resources and clinical education materials)
- □ Provide contact information for service provider and care coordinator – explain the difference between patient’s CCAC community care coordinator and service provider
- □ Remind patient you will be conducting a follow-up phone call (within 4-7 days)
- □ Emphasize importance to patients of bringing personalized *My Story* and Plan of Care to all follow-up appointments and back to hospital if readmitted
- □ Conduct post-discharge visit to patient’s home (if needed)

**Documentation**
- The estimated length of stay should be documented, within 24 hours of admission, in the patient’s healthcare record (following discharge rounds).
- The treatment plan should be documented, in the healthcare record. The plan should be reviewed daily (during discharge rounds) and updated in response to changing needs.
- The discharge plan should be documented in the healthcare record, within 24 hours of admission. The plan should be reviewed daily and updated in response to changing needs.
- Relevant internal and external referrals (diagnostics, CCAC, SDL etc.) should be made to the various members of the care team and this should be documented in the healthcare record.
- The *My Story* and *Plan of Care* should be completed as per transition pathway and on the patient healthcare record.
- The record should be kept up to date and legibly signed by each member of the team involved in the patient’s discharge.

### 2) Physicians – Working within the *Seamless* approach

<table>
<thead>
<tr>
<th>1. Standard <strong>work at admission</strong></th>
<th>Check in with team on Monday mornings at 9:00 to 9:30 a.m.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Receive update on caseload</td>
</tr>
<tr>
<td></td>
<td>• Identify new patients</td>
</tr>
<tr>
<td></td>
<td>• Share updates from weekends</td>
</tr>
<tr>
<td></td>
<td>• Share updates on patient statuses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Standard <strong>work during hospital stay</strong></th>
<th>Communicate with team via text throughout day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Attend team rounds at 1:30 p.m. in 1C meeting room</td>
</tr>
<tr>
<td></td>
<td>• SPAMM format – participation includes: transition coordinator, MRP, OT, PT, charge nurse</td>
</tr>
<tr>
<td></td>
<td>• MRP role: discuss medical status, expected discharge date (EDD) and plan</td>
</tr>
<tr>
<td></td>
<td>• See Appendix 3.2D for team rounds protocol</td>
</tr>
<tr>
<td></td>
<td>Sign off on any medical CCAC referrals (as needed)</td>
</tr>
<tr>
<td></td>
<td>Fill out any health reports (as needed)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Standard <strong>work at discharge</strong></th>
<th>On last day of two week rotation:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Prepare prescriptions and discharge orders for following Monday</td>
</tr>
<tr>
<td></td>
<td>Sign-off on daily discharges before 10 a.m.</td>
</tr>
</tbody>
</table>
3) Physiotherapist (PT) – Working within the *Seamless* approach

| 1. Standard work at admission | Check in with team in morning at 9:00 a.m.  
|                             | Obtain and review patient list in MediTech  
|                             | Visit patient – either in ED or on unit depending on their location  
|                             | Obtain information to initiate and complete *My Story* within 24 hours of admission (See Appendix 3.1D for example of *My Story*)  
|                             | • If you see a patient before the TC, begin *My Story* assessment and provide recommendations for streaming patients into transition pathways  
|                             | • Facilitate conversations with patients/families about transition plan and process  
|                             | Communicate with existing, external PT/OT providers (dependent on patient)  
| 2. Standard work during hospital stay | Attend daily team rounds at consistent time  
|                             | • SPAMM format (See Appendix 3.2D for team rounds protocol)  
|                             | • PT/OT role: discuss functional status and barriers to discharge, contribute to appropriate reassessment and streaming of patients  
|                             | Complete *Plan of Care* and *My Story*  
|                             | Connect with integrated care team members with patient updates regularly  
|                             | Complete MED2020  
|                             | Participate in family meetings  
|                             | Prioritize patients to see based on transition pathways  
| 3. Standard work at discharge | Ensure completion of discharge documentation for CCAC referrals/services  
|                             | Complete *Plan of Care* day before patients’ projected discharge date  
|                             | Communicate with external providers (as needed) to support complex patients |
4) Occupational therapist (OT) – Working within the **Seamless** approach

| 1. Standard work at admission | Check in with team in morning at 9:00 a.m.  
| | Obtain and review patient list in MediTech  
| | Visit patient – either in ED or on unit depending on their location  
| | Obtain information to initiate and complete *My Story* within 24 hours of admission (See Appendix 3.1D for example of *My Story*)  
| | - If you see a patient before the TC, begin *My Story* assessment  
| | - Provide recommendations for streaming patients into transition pathways  
| | - Facilitate conversations with patients/families about discharge plan and process  
| | Communicate with existing, external PT/OT providers (dependent on patient)  
| 2. Standard work during hospital stay | Attend daily team rounds at standard time  
| | - SPAMM format (See Appendix 3.2D for team rounds protocol)  
| | - PT/OT role: discuss functional status and barriers to discharge, contribute to appropriate reassessment and streaming of patients  
| | Complete *Plan of Care* and *My Story*  
| | Connect with integrated care team members with patient updates regularly  
| | Complete MED2020  
| | Participate in family meetings  
| | Prioritize patients to see based on transition pathways  
| 3. Standard work at discharge | Ensure completion of discharge documentation for CCAC referrals/services  
| | Complete *Plan of Care* day before patients’ projected discharge date  
| | Communicate with external providers (as needed) to support complex patients |
1.3 Physician Orientation

Welcome to the Seamless Transitions team. We strive to improve patient experiences and outcomes by focusing on transitions in care, starting from the time of admission.

What does the transition coordinator (TC) do?

TC meets your patient within 24 hours of admission (except weekends). They will gather pre-admission information (e.g. level of functioning, living situation, social support, existing services). Together, with you and the patient/family, s/he will develop a post-discharge care plan at the appropriate time during the course of hospitalization. The plan can/will change based on the patient’s clinical course. We aim to make the transition as efficient, safe and seamless as possible. When appropriate, the TC will liaise with community providers to gather information and provide updates.

Who else is on the team?

TC (<name>), PT (<name>), OT (<name>), CC (<name>), etc…

How does it work?

All your patients will be followed by the Seamless Transitions team, and the above allied health consultations will be provided by team members regardless of the patient’s location (even in Emergency Department). You will have team rounds daily at 1:00 pm in 1C with the entire team to go through each patient’s status and transition needs. We expect the entire round to take about 20 minutes. CCAC services will be organized directly during rounds as such you may be asked to fill out CCAC and LTC Health Reports at this time. Team members (including TC and yourself) may liaise with patients and families about their transition plan. Family meetings and bedside rounds will be organized in a per-patient and as needed basis. Team members also often stay in touch throughout the day with text messaging. It is a good idea at the beginning of each day to let your TC know of any new patients. On Mondays, it may make sense to provide the team with some updates from the weekend or get updates from the team if you are taking over.

Discharge Documentations

You are required to complete the usual discharge documentations, including discharge prescriptions, dictated discharge summaries, discharge orders, referrals, etc. Your patients will also receive a My Story and Your Care Plan documents from the Seamless Transitions team upon discharge outlining their post discharge care plan. There is a section “Instruction from the doctor” that you can contribute.

Welcome!
## 1.4 Core competencies for Transition Coordinator (Social Worker/DCP/Care Coordinator)

<table>
<thead>
<tr>
<th>Clinical expertise</th>
<th>Personal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Problem solving</td>
<td>• Advocacy</td>
</tr>
<tr>
<td>• Ability to see patient holistically</td>
<td>• Negotiation</td>
</tr>
<tr>
<td>• Identifying needs and solutions</td>
<td>• Assertiveness</td>
</tr>
<tr>
<td>• Knowing what is available (e.g. services in community)</td>
<td>• Prioritization/time management</td>
</tr>
<tr>
<td>• Develop a care plan</td>
<td>• Professionalism</td>
</tr>
<tr>
<td>• Clinical skills</td>
<td>• Flexibility</td>
</tr>
<tr>
<td>• Completing assessments</td>
<td>• Proactive</td>
</tr>
<tr>
<td>• Building and maintaining relationships with patients</td>
<td>• Teamwork</td>
</tr>
<tr>
<td>and families</td>
<td>• Confidence</td>
</tr>
<tr>
<td></td>
<td>• Managing expectations</td>
</tr>
<tr>
<td></td>
<td>• Able to give and receive constructive feedback</td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td><strong>Admin</strong></td>
</tr>
<tr>
<td>• Teaching, knowledge sharing</td>
<td>• Telephone communication</td>
</tr>
<tr>
<td>• Change management (setting and dealing with expectations of patients, colleagues,</td>
<td>• Written communication</td>
</tr>
<tr>
<td>and learning new process)</td>
<td>• Verbal communication (with team members,</td>
</tr>
<tr>
<td></td>
<td>patients, families)</td>
</tr>
<tr>
<td>• Team management</td>
<td>• Documentation</td>
</tr>
<tr>
<td>• Building and maintaining professional relationships</td>
<td></td>
</tr>
</tbody>
</table>
1.5 Job description for Transition Coordinator (Social Worker/DCP/Care Coordinator)

**Position Summary – Transition Coordinator (TC)**

Transition Coordinator is a newly designed role intended to support the safe, timely and consistent transitions of patients from hospital to the community. Functioning as the key point of contact for transition planning between patients, hospital and community care teams, the TC initiates and coordinates transition plans focused on patient and family goals. Working collaboratively with an integrated, interdisciplinary care team and community partners, the TC identifies gaps in care, barriers to discharge and required post-hospital services to enable seamless transitions for patients. The TC understands flow and capacity challenges within the hospital and community sector, leveraging this knowledge to plan and execute individualized care plans that give patients confidence to leave hospital.

**Responsibilities**

Collaborates with the interprofessional team to:

**Assess and engage patients**

- Coordinate and complete the baseline assessments of the patient’s functional, psycho-social and medical status
- Works with patients and families to develop a plan that promotes self-management of long-term health needs by linking to resources that will facilitate changes in behavior, attitudes, feelings and/or the environment
- Serves as an advocate, main contact and source of information to the patient and family during hospital stay and for up to two weeks after discharge

**Set goals and plan for post-hospital care**

- Evaluate the need for post-hospital services, providing recommendations and identifying services for post-hospital care plan based on patient’s pre-admission functional baseline and changes during hospitalization
Determine eligibility for post-hospital community services, such as CCAC, long-term care, Adult Day Programs, retirement homes, hospices and SDL

Engage patient and family in the planning and development of the post-hospital care plan. Review completed plan with patient and family, ensuring they understand what happens next in their plan of care.

Utilize a “teach back” model to ensure patient and family understand the transition plan

Maintain awareness of patient care needs during hospitalization and communicate any barriers to discharge to care team

Reassess and modify the plan as required

Implement and coordinate transition plan

Establish contact and constant communication with members of the multidisciplinary team, CCAC community care coordinator, community service providers and community health care providers (including family physicians, pharmacies and specialists) to exchange information relating to patients’ psychosocial functioning and plan of care

Identify the need for, arrange and lead care conferences and family and team meetings

Facilitate team rounds to gather pertinent information from care team members to develop, revise and execute patient transition plan

Liaise with the CCAC and appropriate community agencies to arrange the services to support the post-hospital care plan

Complete applications for post-hospital care programs (e.g. CCAC, long-term care Home, Supports for Daily Living, in-patient rehabilitation and convalescent care)

Specifically for long-term care:

- Facilitate long-term care application process, providing information to patient and families about long-term care options
- Update and monitor long-term care home waiting lists as patient needs and priorities change
- Propose appropriate patients for long-term care home vacancies
- Ensure completion of long-term care applications before submitting to homes for processing

Initiate and facilitate discussions around copayment as required

Resolve complex issues with patient/family/SDM/POA through use of conflict resolution meetings, providing mediation and advocacy with internal and external partners

De-escalate heightened emotional situations through effective communication

Escalate potential high risk issues to senior leadership in accordance with escalation policy (to be developed)

Provide crisis intervention and adjustment counselling

Intervene to alleviate high risk or vulnerable situations (e.g. elder abuse/neglect, homelessness, substance abuse, isolated mental health patients, etc.)

Complete mandatory reporting (PGT or police) as appropriate
● Assist with adjustments related to health issues (palliation, new diagnosis, etc.)
● Provide resource counselling through education and information as needed

Competencies

Demonstrated ability in:

● Communication and collaboration, positive interpersonal relationships, critical thinking and time management skills
● Positive conflict resolution and negotiation
● Establishing viable and resourceful solutions to optimize patient outcomes and support their rights through knowledge of health care and social resources
● Utilizing evidence-based practices in the process of transition planning
● Setting priorities and effectively resolve challenging situations involving multiple stakeholders, patients and families
● Creating a shared vision for patients, family, and health care teams
● Resourceful problem solving to develop solutions that are patient-centered within the current system's constraints, but also to imagine creative solutions in situations where the current system falls short
● Flexible, adaptable and responsive to change
● Accountable for own actions and decisions, making decisions within the scope of the position and referring issues/problems/events to the manager as required
● Adept in the use of MS Office applications (e.g., Word, Excel, Outlook, PowerPoint, etc.)

Communication and interpersonal skills

● Ability to use courtesy and tact to explain and exchange data in all interactions
● Ensures effective and professional communications with all internal/external contacts
● Ability to work independently as well as within an multidisciplinary team
● Respects ethnic, spiritual, linguistic, familial and cultural differences
● Ability to maintain confidential information
● Ability to communicate effectively with other professionals, related to specific patient needs, to ensure information transfer
● Ability to communicate in French or another language an asset
● Strong negotiation, problem solving, conflict resolution, facilitation skills and the ability to work collaboratively with internal and external contacts
● Excellent customer service skills
● Empathy to sensitive issues
Qualifications and experience

- University degree in health discipline required (Nursing, Social Work, Physiotherapy, Occupational Therapy) – There was no consensus at working group as to whether Masters degree would be required to perform this role, so it was agreed HR will collaborate with working group to determine education requirements for this role
- A member in good standing with their applicable regulatory body below:
  - College of Nurses of Ontario
  - Ontario College of Social Workers and Social Service Workers
  - College of Physiotherapists of Ontario
  - College of Occupational Therapists of Ontario
- Two (2) to five (5) years recent experience in clinical experience in an adult acute care hospital setting
- Working knowledge of hospital and community regulation impacting transition planning (Public Hospitals Act, Substitute Decision-Making Act, Consent to Treatment Act, Health Care Consent Act, Mental Health Act, etc.)
- Working knowledge of community resources, including any applicable regional programs, and the initiative to proactively search for new resources
- Knowledge of the impact of social determinants of health on transition planning (e.g. length of stay, patient flow, etc.)
- Transition planning experience an asset
2.1 Transition planning tools used at admission

Appendix 2.1A – How to obtain patient list from MediTech

1. Select MEDITECH LIVE
2. Go to REPORTS
3. Select ADM REPORTS
4. Select HOSPITALISTS CENSUS
5. Press ENTER
6. PRINT

Appendix 2.1B – Sample script for Transition Coordinator introduction to patient

“Hi, my name is ____________________. I am part of the team that works with Dr. ________________. I am here to assess how you’re managing at home. I will work with you, your family and the other care team members to coordinate the care you need to transition home. If you or your family members have any questions or concerns during your stay, I will be able to answer them during our daily visits.”
Appendix 2.1C – Transition Pathways (criteria for streaming patients)

<table>
<thead>
<tr>
<th>SIMPLE</th>
<th>ROUTINE</th>
<th>COMPLEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Basic transition needs only, no community service coordination required</td>
<td>• Community service coordination required, one service (new), resume services (no changes)</td>
<td>• Community service coordination required, multiple services, resume services (additional service required)</td>
</tr>
<tr>
<td>• Promote self-care and facilitate/provide health teaching</td>
<td>• Communication with community service providers</td>
<td>• Communication with multiple community service providers</td>
</tr>
<tr>
<td><strong>Expected discharge destination:</strong> home with no services</td>
<td><strong>Expected discharge destination:</strong> home with support (community and/or CCAC service)</td>
<td>• External community providers required to participate in planning processes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has behavioural issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Expected discharge destination:</strong> wait at home LTC, new discharge destination required</td>
</tr>
</tbody>
</table>

**Note:** Please see key activities (page 55 to 63) for the standard work requirements to transition patients along each pathway.
Appendix 2.1D – My Story (baseline assessment initiated within 24 hours of admission)

Who am I?

My name is: __________________________ I like to be called: __________________________
I am ________ years old.

Personal Information

<table>
<thead>
<tr>
<th>My emergency contact person is:</th>
<th>The person who helps me make decisions about my health (SDM) is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: _________________________</td>
<td>Name: ____________________________________________________</td>
</tr>
<tr>
<td>Relationship: __________________</td>
<td>Relationship: _______________________________________________</td>
</tr>
<tr>
<td>Phone Number(s): __________________</td>
<td>Phone Number(s): __________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People who depend on me:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: __________________</td>
<td>For what: ____________________________________________________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I use hearing aids:</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I wear dentures:</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>I wear glasses:</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>I wear prosthetics:</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you think you are getting more forgetful?</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you think people have a hard time understanding you?</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I speak English:</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I read English:</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

The language that I speak at home is: ________________
I would like to have a translator:  □ Yes  □ No

<table>
<thead>
<tr>
<th>I have had _______ falls in the last 6 months.</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, what happened? ________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I have visited the Emergency room or have been discharged from hospital in the last 30 days?  □ Yes  □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, why and how often? -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To get to where I need to go, I: (check all applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Drive  □ Take the bus  □ Take a taxi  □ Have someone drive me  □ Trans Help  □ Other: __________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My job is: □ Employed  □ Unemployed  □ Retired  □ Disability______________  □ Other: _________________________</th>
</tr>
</thead>
</table>

| The task I need to be able to do at work or at home are: ____________________________________________ |

<table>
<thead>
<tr>
<th>I have control over my bladder/bowels:  □ Yes  □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>To help me in my washroom, I have: □ Grab bars  □ Raised toilet seat  □ Shower chair or bench  □ Commode chair  □ No aids required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I have a special diet: □ Yes  □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please describe: ______________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I use special medical equipment (check all applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Catheter  □ Special I.V/Vascular Access Device  □ Feeding tube  □ Insulin  □ CPAP  □ Oxygen  □ Trach  □ Vac dressing pump  □ Other</td>
</tr>
</tbody>
</table>

|______________________________________________________________________________________________|
|______________________________________________________________________________________________|
## Home Situation

I live in a: □ Bungalow □ 2 Storey □ Townhouse □ Apartment □ Retirement Home ___________ □ Long Term Care ___________

□ Other (specify) ___________________________

I use stairs at home: □ Yes □ No

Do you need help getting out of bed/chair? □ Yes □ No

To help me move around I use: □ Cane □ Walker □ Scooter □ Wheelchair □ No aids required

## Community Supports

CCAC Prior: □ Yes □ No

If yes, name: Community Care Coordinator: ________________________________

Current CCAC Services: □ Nursing □ PT □ OT □ RD □ SLP □ PSW □ Other__________________________________

Day Program: __________________________________________________________

Home Help (non-profit): □ Supports for Daily Living □ March of Dimes □ Links 2 Care □ Dorothy Ley

Home Help (private): __________________________________________________

Food Services: □ Meals on Wheels □ Copper Country □ Grocery Delivery ___________________________________________

Pharmacy: ___________________________ Fax # ___________________________ Other Supports:

____________________________________________________

## Initial Assessment

Transition Categorization: □ Simple □ Routine □ Complex

Discharge Plan: ______________________________________________________________________

Comments: _______________________________________________________________________

Community care team members notified on admission: Community Care Coordinator: □ Yes □ No

Family Doctor: □ Yes □ No

If yes, name: ___________________________ Fax # ___________________________ □ No Family Doctor

Other (specify): ____________________________________________________________________

Information taken from: __________________________________________________________

Last verified on: ___________________________ Last verified by: ___________________________
### 3.2 Transition planning tools used during patient’s hospital stay

**Appendix 3.2A – Plan of Care – Simple patients (for providers)**

<table>
<thead>
<tr>
<th>Patient’s Name’s Plan of Care</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Most recent hospital visit</th>
<th>Last verified:</th>
<th>Last verified by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of visit:</td>
<td>Date of discharge (if applicable):</td>
<td></td>
</tr>
<tr>
<td>Reason for visit:</td>
<td>Complications:</td>
<td></td>
</tr>
<tr>
<td>Name of hospital physician:</td>
<td>Telephone #:</td>
<td></td>
</tr>
<tr>
<td>Key advice from hospital physician:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up appointment made with:</td>
<td>Date of follow-up appointment:</td>
<td></td>
</tr>
</tbody>
</table>
## Health Issues

<table>
<thead>
<tr>
<th>Physical Health</th>
<th>Social Health</th>
<th>Mental Health</th>
</tr>
</thead>
</table>

## Post-hospital Care Plan

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Treatment/Analysis</th>
<th>Function at discharge</th>
<th>Plan (or recommendations)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medication list and medication reconciliation attached?** □ Yes □ No

**Prescriptions faxed?** □ Yes □ No

**Pharmacy:** Phone Number:
Appendix 3.2B – *Plan of Care* – Routine and complex patients (for providers)

### 's Plan of Care

<table>
<thead>
<tr>
<th>Most recent hospital visit</th>
<th>Last verified:</th>
<th>Last verified by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of visit:</td>
<td>Date of discharge (if applicable):</td>
<td></td>
</tr>
<tr>
<td>Reason for visit:</td>
<td>Complications:</td>
<td></td>
</tr>
<tr>
<td>Name of hospital physician:</td>
<td>Telephone #:</td>
<td></td>
</tr>
<tr>
<td>Key advice from hospital physician:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up appointment made with:</td>
<td>Date of follow-up appointment:</td>
<td></td>
</tr>
</tbody>
</table>

**Medication list and medication reconciliation attached?**  □ Yes  □ No

**Prescriptions faxed?**  □ Yes  □ No

**Pharmacy:**  

**Phone Number:**
## Health Issues

<table>
<thead>
<tr>
<th>Physical Health</th>
<th>Social Health</th>
<th>Mental Health</th>
</tr>
</thead>
</table>

## Post-hospital Care Plan

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Treatment/ Analysis</th>
<th>Function at discharge</th>
<th>Plan (or recommendations)</th>
</tr>
</thead>
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## Community Care Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Role or relationship</th>
<th>Organization</th>
<th>Telephone #</th>
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Appendix 3.2C – My Care Guide (for patients)

My Care Guide

This is your personalized care plan. It outlines information your care providers need to continue your care in the community. Please take this to all medical appointments, including visits to your family doctor.

<table>
<thead>
<tr>
<th>Important Contacts</th>
<th>Name</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Doctor</td>
<td></td>
<td></td>
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<tr>
<td>Hospital Transition Coordinator</td>
<td></td>
<td></td>
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<tr>
<td>Community Care Coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
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</tbody>
</table>
### Care Guide

#### How I might feel and what to do

<table>
<thead>
<tr>
<th>I might feel</th>
<th>What to do</th>
</tr>
</thead>
</table>

#### Changes to my routine

(For e.g. activity, diet.....) | Instructions

#### Other information

---

#### Appointments I have to go to

<table>
<thead>
<tr>
<th>Go See</th>
<th>For</th>
<th>On</th>
<th>Booked</th>
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<tbody>
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March 2015

Notes:
Appendix 3.2D – How to facilitate discharge rounds (SPAMM model)

- Transition Coordinator (TC) leads the rounds (discharge oriented rounds)
- Each patient is discussed
  - Share *My Story* – who they live with, what their functioning is, currently community services, expected discharge plan (when medically stable) etc.
- Each team members provides input based on their expertise
  - Physician and charge nurse talk about medical status. Physician classifies expected discharge date (EDD).
  - OT – functional status (IADL)
  - PT – mobility status
  - TC (SW/DCP) – social status and intervention, options for community care/services/program
  - CCAC care coordinator – social status, options for community care/services/program
  - Other allied as necessary
- Identify barriers/challenges to discharge
  - Proactively work through those issues to move discharges along
- Discuss projected discharges for the following two days
- Reassess patients every day, based on team's input, for readiness for discharge
- Communicate any concerns from patients/family with integrated care team
- Ensure health reports completed
  - If patient requires CCAC services, attain medical referral orders signed off
### SPAMM Format – Seamless Transitions Discharge Rounds

<table>
<thead>
<tr>
<th>Patient name:</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Problem</td>
<td>Action</td>
</tr>
</tbody>
</table>

**Social**
- Lives alone, self-employed, no drug plan

**Per Os**
- Nutrition screen shows risk of being malnourished

**Activities for Self Care (including ADL and mobility)**
- Needs assistance with peri care, needs assistance to get out of bed

**Mental**
- Poor short memory, poor insight, aggravated by loud noise

**Medical**
- Reason for/meaning of test results, confirmation of diagnosis, outstanding tests and expected discharge date.

Please note that *My Story* is accessible to the team and therefore there is already a summary of the information in each area available to all. The discussion for rounds then is to add any additional information gathered since the previous day but mostly to highlight the issues in each of these categories and develop the action required.
Appendix 3.2E – Frequent topics of conversations with patients and families

Your patients and their families may have questions for you about the patient’s health status and advanced care planning during their length of stay. Below is a list of topics frequently discussed with patients and families during bedside rounds and family meetings you should familiarize yourself with (e.g. resources available, ways to approach difficult conversations) to be able to appropriately address patient and family concerns.

- Future planning (long-term care, retirement, palliative, Power of Attorney, finances, progression of diagnosis and health education)
- Caregiver resources
- Details of care plan (documents for reference such as *My Story*, Plan of Care, contact information for providers, etc.)
- Community resources and how to access them in the community
- Importance and purpose of *My Story* and Plan of Care
- Difference between retirement home and long-term care (LTC)
- Cost of retirement home and LTC (different levels)
- Who their care team is and their roles in the circle of care
Appendix 3.2F – Teach Back methodology

One of the easiest ways to close the communication gap between patients and educators is to use the "teach-back" method. Teach-back is a way to confirm that you have explained to the patient what he or she needs to know in a manner that the patient understands. Patient understanding is confirmed when he or she explains the information back to you in his or her own words. Lack of understanding and errors can then be rectified with further directed teaching and reevaluation of comprehension.

A video demonstration of the teach-back method is available at: http://www.nchealthliteracy.org/teachingaids.html.

- This is not a test of the patient's knowledge; it is a test of how well you explained the concepts.
- Be sure to use this technique with all your patients, including those who you think understand as well as those you think are struggling with understanding.
- If your patient cannot remember or accurately repeat what you asked, clarify the information that you presented and allow the patient to teach back again. Do this until the patient is able to correctly describe your directions in his or her own words.

Remind patients that all the information they need to know is in the My Care Guide or additional material provided in their discharge package. This is not a memory test; they simply need to know where in the guide the information is located. After reviewing how to locate the information in the guide, ask a series of other questions. After several rounds of teach-back, if the patient still has trouble the team should be notified and an alternative plan should be created.

Method:

- Plan - your approach. Think about how you will ask your patient to teach-back information based on the topic you are reviewing. Keep in mind that some situations will not be appropriate for using the teach-back method.
- Use handouts - Reviewing written materials (such as, My Care Guide, brochures, pathways etc.) to reinforce the teaching points can be very helpful for patient understanding.
- Clarify - If patients cannot remember or accurately repeat what you asked them, clarify your information or directions and allow them to teach it back again. Do this until the patient is able to correctly describe in their own words what they are going to do, without parroting back what you said.
- Practice - It may take some getting used to, but studies show that once established as part of a routine, it does not take longer to perform.

Source: NC Program on Health Literacy http://www.nchealthliteracy.org/teachingaids.html
Appendix 3.2G – Tips for facilitating a family meeting or case conference

- Determine who will attend the meeting: □ the patient, □ family members, □ charge nurse/primary nurse, manager, □ members of the interprofessional team, □ community service providers, □ family doctor
- Identify who will be leading the meeting - in most case this will be the Transition Coordinator
- Establish guideline on how the meeting will be conducted
- Ensure all team member know when the meeting will occur
- Ensure each member of the team understands the role and responsibilities of all other members
- Document all decisions made - in most case this will be the Transition Coordinator
- Ensure one person is responsible for completing the patients plan of care and that they are aware of that responsibility

<table>
<thead>
<tr>
<th>Family meeting or case conference</th>
<th>□ Transition Coordinator chairs the family meeting or case conference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Transition Coordinator ensures introductions are made and the purpose of the family meeting or case conference is stated</td>
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<tr>
<td></td>
<td>□ Transition Coordinator sets expectations for the conference such as ground rules, patient-centred focus, strength based, problem solving, coordinating and planning</td>
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<tr>
<td></td>
<td>□ Transition Coordinator starts with issues/goals identified, patient/family strengths and resources, generate options for care approaches or additional resources to assist in care delivery plan goal attainment, identify the who, what, when, where and how long</td>
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<tr>
<td></td>
<td>□ If the patient/SDM or family involved, Transition Coordinator ensures their input is enlisted at all times and their support for the care approaches</td>
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<tr>
<td></td>
<td>□ Participants identify any new goals for discussion</td>
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<tr>
<td></td>
<td>□ Participants try to reach consensus on the care delivery plan and if not possible, identify that the goal will be attempted and reviewed with an associated timeframe</td>
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<tr>
<td></td>
<td>□ Transition Coordinator clarify ongoing communication processes with the participants to ensure continued coordination and how, when the new goals of care will be monitored, reviewed and evaluated</td>
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<td></td>
<td>□ If relevant, participants identify safety or risk issues and a plan to address</td>
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<td></td>
<td>□ If relevant, Transition Coordinator identifies the next family meeting or care conference meeting time, place, and date</td>
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</table>
# Transition planning tools used at discharge and follow-up

**Appendix 3.3A – Discharge Checklist**

<table>
<thead>
<tr>
<th>Transition Pathway</th>
<th>Date</th>
<th>Initials &amp; Role</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>SIMPLE</strong></td>
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<tr>
<td>Family physician appointment arranged and discharge summary faxed</td>
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<tr>
<td>Follow up appointments booked &amp; communicated to patient</td>
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<tr>
<td>Lab/test requisitions provided</td>
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<tr>
<td>Prescription faxed to pharmacy</td>
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<tr>
<td>Transportation for discharge confirmed</td>
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<tr>
<td>Referrals for follow up care provided i.e. physio, next steps</td>
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<tr>
<td>Resources provided i.e. vendors list</td>
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<tr>
<td>Other – SLP, Dietitian, etc.</td>
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<tr>
<td><strong>ROUTINE - all of the above</strong></td>
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<td>Community services arranged and confirmed</td>
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<tr>
<td>Contact info for Community providers given to patient</td>
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<tr>
<td>Confirmation of delivery of equipment/supplies</td>
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<tr>
<td>Care Plan provided to patient</td>
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<tr>
<td>Resources provided re. clinical education</td>
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<tr>
<td>Provide list of relevant community resources</td>
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<tr>
<td>Confirmation of medication arrangements</td>
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<tr>
<td>Other – SLP, Dietitian, etc.</td>
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Appendix 3.2B – Script for post-discharge phone calls (completed by Transition Coordinator)

Hello, my name is ______________, and I’m calling from Credit Valley Hospital. I’m checking in because it has been a few days since you went home and I wanted to see how you are doing. How are you feeling?

I’d also like to ask you a few questions about your post-hospital care plan.

- Were you able to get your prescriptions filled?
- Are you taking your medication(s) as your doctor ordered?
- Did you make your follow-up appointments (if the hospital did not do this before discharge)?
- Is there any reason you might not be able to keep your follow-up appointments?
- Do you have any questions about your care plan?
- Do you have any questions about the follow up process or any instructions that we have provided?

Thank you for speaking with me today. If you have any additional questions, please call me at (phone number).

Note: These calls should occur 48 to 72 hours after the patient leaves the hospital to ensure the patient understands the discharge instructions and is able to comply with the treatment plan. The calls are completed by the patient’s Transition Coordinator.
Meet the Design Team

Back row (L-R): Dr. Terence Tang (THP, CVH); Avori Cheyne (Communications Specialist, MHCCAC), Melanie Blake (OT, THP); James Yuan (Performance Management, MHCCAC); Suzanne Nevers (PT, THP), Michelle Samm (Project Lead), Dr. Vipan Nikore (THP-CVH); Germaine Subnaik (Patient Navigator, THP)

Front row (L-R): Debbie Park (PT, THP); Irina Kaskanik (Social Worker, THP); Cara Espinoza (Nurse, THP); Tracey-Anne Hasfal (Care Coordinator, MHCCAC)

Missing: Charmaine Lodge (Professional Practice Advisor, MHCCAC), Janet Moorehead (OT, THP), Ellen Branitescu (Care Coordinator, MHCCAC)