Home to Hospital to Home (H2H2H) Transitions Potentially Better Practices:

Rationale and Evidence

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ALBERTA MEDICAL ASSOCIATION | ACTT Accelerating Change Transformation Team

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1.1 Establish a multidisciplinary quality improvement team and consider including a patient with lived experience

Rationale

"Those who do the work change the work."

Involving team members on a quality improvement team empowers them to own the work. Team members are an important source of solutions as they are experts in their own workflow. Bringing in members from all areas of the team allows for the most effective decision making because everyone brings their perspective to the table.[1] Teams who work effectively together are better able to implement improvements to patient care. Research suggests that teams with greater cohesiveness are associated with better clinical outcome measures, lower burnout, and higher patient satisfaction.[2–5]

For optimal care to occur, both patients and clinicians need to be involved.[6] Patients and their families bring personal knowledge on their life circumstances and preferences, while clinicians offer guidance and advice on treatment and intervention options. Patient-centered care occurs when clinicians engage patients in a way that builds trust, motivation, and confidence.

This potentially better practice encourages meaningful engagement of patients as advisors or participants on quality improvement teams. Persons with lived experience can be a patient or a family member of a patient.[7] In Alberta, teams that engage patients when developing and implementing practice changes report stronger patient-centered processes that incorporate lived experience results in greater benefits to patients. [8,9]

Evidence

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2. Bower P, Campbell S, Bojke C, Sibbald B. Team structure, team climate and the quality of care in primary care: an observational study. Qual Saf Health Care. 2003 Aug;12(4):273–9.
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1. IMPROVE THE PATIENT EXPERIENCE

1.2 When appropriate, invite patients to bring a caregiver or family member to a follow-up appointment

Rationale

Family members or caregivers often have a role in supporting patient hospital-to home transitions. Patients, family, and caregivers are listed as one of the key stakeholders' groups within the H2H2H Transitions Guideline. However, they often report feeling unprepared to support this transition.[1] Involving them in the follow-up appointment can aid in addressing any questions caregivers may have.

Research has found that for older adults discharged to a community setting, the integration of caregivers into the discharge planning process reduces the risk of hospital readmission.[2] Continuing that involvement after discharge can result in improved outcomes for the patient.[3]

Potential roles for family members or caregivers in hospital to home transitions of care may include attending follow-up appointments; bringing a complete list of prescriptions currently taken (e.g., Green Sleeve with medication list, goals of care plan) and updated with any medications received while in hospital; and discussing any questions or concerns on behalf, or in conjunction with the patient; and documenting important information.

Evidence

1. Gauvin F, Ganann R, Heald-Taylor G, Markle-Reid M, McAiney C, Moat K, et al. Citizen brief: Engaging older adults with complex health and social needs, and their caregivers, to improve hospital-to-home transitions in Ontario [Internet]. Hamilton, ON: McMaster Health Forum; 2019 Nov. Available from: https://www.mcmasterforum.org/docs/default-source/product-documents/citizen-briefs/transitional-care-cb.pdf?sfvrsn=1eb957d5_2
2. Rodakowski J, Rocco PB, Ortiz M, Folb B, Schulz R, Morton SC, et al. Caregiver Integration During Discharge Planning for Older Adults to Reduce Resource Use: A Metaanalysis. J Am Geriatr Soc. 2017 Aug;65(8):1748–55.
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2. IDENTIFY PANELED PATIENTS FOR CARE IMPROVEMENTS

2.1 Upon receipt of admit notification, develop a process to provide hospital team with any relevant patient information

Rationale

Admission to hospital is a transition point that requires organized and prompt communication between a patient's identified circle of care and the hospital.[1] Awareness of an admission presents the opportunity for bidirectional flow of information between a patient's circle of care and the hospital (i.e., informational and management continuity). The patient's circle of care can contact the hospital team (e.g., attending physician) to convey vital information, such as a patient's history, care plan, medications and any social or family dynamics that may affect care.[2–4] This can result in improved informational and management continuity across care settings.[5]

Evidence

1. Greenwald J, R. Denham C, Jack B. The Hospital Discharge: A Review of a High Risk Care Transition With Highlights of a Reengineered Discharge Process. J Patient Saf. 2007 Jun 1;3:97–106.
2. Tang N. A primary care physician's ideal transitions of care--where's the evidence? J Hosp Med. 2013 Aug;8(8):472–7.
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4. Kim CS, Coffey CE. Transitions of care: optimizing the handoff from hospital-based teams to primary care physicians. Am Fam Physician. 2014 May 1;89(9):706–7.
5. Primary Health Care Integration Network. Alberta's home to hospital to home transitions guideline: Keeping Albertans and their circle of care connected [Internet]. Alberta Health Services; 2020 Nov. Available from: https://www.albertahealthservices.ca/assets/info/hp/phc/if-hp-phc-phcin-hthth-guideline.pdf

2. IDENTIFY PANELED PATIENTS FOR CARE IMPROVEMENTS

2.2 Develop a process to identify patients discharged from the hospital (using CII/CPAR)

Rationale

Knowing when your patients have been discharged from the hospital allows primary care clinic teams to follow up with appropriate care and reduce the likelihood of readmission.

There are currently two automated delivery methods by which primary care clinics may be receiving information about their patients discharged from hospital. The first method is via 'Summative Notes' delivered from Connect Care enabled facilities into a provider's EMR via eDelivery. **These are sent to the primary provider identified by the patient on admission.** There are several different types of Summative Notes selected for eDelivery, for more information, see this memo from AHS.

The second method is via CII/CPAR eNotfications which are automated messages delivered directly to the physician's electronic medical record (EMR) via Community Information Integration (CII). **eNotifications will be sent to the physician to whom the patient is paneled in the Central Patient Attachment Registry.** ENotifications are sent from almost every AHS inpatient, urgent and emergency care facility in the province no matter which system they are using.

Providers who are not submitting panels through CII/CPAR will not be able to receive eNotifications. Clinics should consider signing up for CII/CPAR to receive these notifications, in addition to many more benefits including improved relational and informational continuity. Together, eNotifications and Summative Notes help to fill in the gaps that can sometimes occur during transitions of care.

In addition to the automated methods mentioned above, some jurisdictions have local workarounds to notify providers in their area about admissions and discharges at local facilities. These also help to close gaps during transitions of care.

2. IDENTIFY PANELED PATIENTS FOR CARE IMPROVEMENTS

2.3 Partner with your PCN when you are accepting new patients to your panel

Rationale

Hospitalized patients are less likely to be readmitted if they have a regular primary care provider.[1–3] Finding a doctor who is accepting patients can be a challenge. Many Alberta PCNs have processes to support this task. Additionally, Alberta Find a Doctor (AFAD) is a website where patients can find a doctor accepting patients. Submitting your information to AFaD is beneficial to both patients and providers in making these connections.

Evidence

1. Nkemdirim Okere A, Sanogo V, Balkrishnan R, Diaby V. A quantitative analysis of the effect of continuity of care on 30-day readmission and in-hospital mortality among patients with acute ischemic stroke. J Stroke Cerebrovasc Dis Off J Natl Stroke Assoc. 2020 Sep;29(9):105053.
2. Choi Y, Nam CM, Lee SG, Park S, Ryu HG, Park EC. Association of continuity of care with readmission, mortality and suicide after hospital discharge among psychiatric patients. Int J Qual Health Care J Int Soc Qual Health Care. 2020 Nov 16;32(9):569–76.
3. Facchinetti G, D'Angelo D, Piredda M, Petitti T, Matarese M, Oliveti A, et al. Continuity of care interventions for preventing hospital readmission of older people with chronic diseases: A meta-analysis. Int J Nurs Stud. 2020 Jan;101:103396.

3. OPTIMIZE CARE PROCESSES

3.2 Develop a process to check each discharge summary for a risk of readmission score (documented in 4.1)

3.3 If a risk of readmission score has not been provided by acute care, develop a process to determine who your high-risk patients are

Rationale

Evidence shows that patients with multiple comorbidities, frequent emergency room visits, age and other frailty indicators are more likely to present for readmission to hospital within a short time following their last discharge.[1–6] Many of these readmissions are preventable, mostly through anticipation, communication and provision of post-discharge supports.

Risk assessment tools can be used to aid clinical judgment in identifying patients who are at higher risk of hospital readmission to support transition planning for the patient. This assessment can be used to assist with deciding the frequency and urgency of follow up in primary care.

AHS uses the "LACE readmission risk index" to stratify patients into those who are at low, moderate or high risk for early readmission. The index considers the patient's length of stay, admission type, comorbidities and frequency of emergency room.[7,8]

If a risk of readmission score has not been provided by acute care, primary care providers will need to develop a process to determine who their high-risk patients are.

Evidence

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6. Alqahtani JS, Njoku CM, Bereznicki B, Wimmer BC, Peterson GM, Kinsman L, et al. Risk factors for all-cause hospital readmission following exacerbation of COPD: a systematic review and meta-analysis. Eur Respir Rev Off J Eur Respir Soc. 2020 Jun 30;29(156):190166.
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3. OPTIMIZE CARE PROCESSES

3.4 Develop a process to offer and manage follow-up care, as appropriate

Rationale

Prompt patient follow-up within primary care is a key strategy to reduce hospital re-admission and emergency department visits post-hospital discharge.[1–9] This reduction has been noted specifically in high-risk patients (i.e., those with multiple conditions and complex needs).

There is not consensus in the literature around the optimal time to schedule a follow-up appointment. Advice varies across organizations and conditions. Both in Canada and internationally, guidelines typically suggest that follow-up for COPD should be between 1 and 2 weeks.[10] Similar guidelines exist for heart failure patients, suggesting that follow-up occur within 2 to 4 weeks.[10] Several provincial and national organizations recommend follow-up within 1–2 weeks of hospital discharge as a measure of health care quality.[11] In Alberta, we are defining "timely follow-up" as occurring within 7 to 14 days for those at high risk of readmission.[12]

Evidence

1. Hernandez AF, Greiner MA, Fonarow GC, Hammill BG, Heidenreich PA, Yancy CW, et al. Relationship between early physician follow-up and 30-day readmission among Medicare beneficiaries hospitalized for heart failure. JAMA. 2010 May 5;303(17):1716–22.
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3. Sharma G, Kuo YF, Freeman JL, Zhang DD, Goodwin JS. Outpatient follow-up visit and 30-day emergency department visit and readmission in patients hospitalized for chronic obstructive pulmonary disease. Arch Intern Med. 2010 Oct 11;170(18):1664–70.
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4. STANDARDIZE DOCUMENTATION

4.1 Standardize entry of admit notifications, discharge notifications and discharge summaries

4.2 Standardize entry of patient risk for hospital readmission in the patient record (Aligns to 3.2)

Rationale

Developing standardized process to document discharge notifications and patient readmission risk can help ensure that appropriate follow-up care is provided in a timely fashion.

Any chance to contribute to improving informational continuity, defined as a state where each provider caring for a patient has access to comprehensive information about the patient's previous health care encounter[1], will result in improved satisfaction for patient and provider[2,3], and improved outcomes for the patient.[4–7]

Evidence

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2. Health Quality Council of Alberta. Understanding patient and provider experiences with relationship, information, and management continuity [Internet]. Calgary, AB: Health Quality Council of Alberta; 2016 Aug. Available from: http://hqca.ca/studies-and-reviews/relationship-information-and-management-continuity/relationship-information-and-management-continuity/
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5. COORDINATE CARE IN THE MEDICAL HOME

5.1 Establish clear roles and responsibilities for supporting patients in transitions

Rationale

In the patient's medical home (PMH) model, care may be provided by a variety of team members (e.g., nurses, mental health consultants, social workers, pharmacists, kinesiologists, dietitians, etc.). Research shows that team based care results in improved quality and outcomes of care and enables successful implementation of primary care innovations.[1–4] The stronger the teamwork among the patient's providers, the better the outcomes.

True team-based care is achieved when multidisciplinary team members collaborate in their efforts. This requires a shift in mental model[1] from a 'physician-centric' referral approach to a collaborative 'team based' approach to provide optimal patient-centered care.[5] When mental models are misaligned, team effectiveness can be significantly reduced.

To implement team-based care, team members must distribute the workload.[5] This then enables patients to experience better access to care, team members to work to the full scope of their practice, which is more challenging and rewarding, and physicians have time to see the more complex patients. High-functioning teams exhibit higher levels of satisfaction, experience less burnout, and achieve higher quality of care.[6–9]. After investing in team development, studies reported improved patient health outcomes, and improved team processes and morale.[6,8–10]

Evidence

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[1] A mental model is more than a set of beliefs and values. Mental models determine what we pay attention to, what options and possibilities we consider, and how we make sense of events and experiences, solve problems, formulate judgments, and ultimately make decisions and act.

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6. COORDINATE CARE IN THE HEALTH NEIGHBOURHOOD

6.1 Communicate as needed post-transition with care providers outside of the medical home (e.g., primary care accessing specialist advice and liaising with homecare or other members of the extended healthcare team)

Rationale

Primary care teams aim to provide whole person care and help patients address what matters most to them, but we can't do this on our own. Sometimes the team members and resources needed by our patients can't be accessed from within the patient's medical home (PMH), and that is where the health neighbourhood comes in. The Health Neighbourhood encompasses the services provided by all healthcare sectors and community supports, with the Patient's Medical Home (PMH) at the centre. The evidence shows that strong links between partners and sharing of information in the health neighbourhood results in improved patient outcomes, safety, and experience; lower costs through reduced duplication of services; improved delivery of prevention services; and more evidence-based patient care.[1]

Just like in the PMH, a high functioning team is able to distribute the workload amongst the various roles.[2] This can be more challenging to coordinate in the health neighbourhood as team members may not be co-located or interact with each other on a frequent basis but having these conversations is a critical step. Teams that are able to distribute the work exhibit higher levels of satisfaction, experience less burnout, achieve a higher quality of care, work to the full scope of their practice, which is more challenging and rewarding, and physicians have time to see the more complex patients.[3–6] This enables patients to experience better care.

Evidence

1. College of Family Physicians of Canada. Best advice guide: Patient's medical neighbourhood [Internet]. Mississauga, ON: College of Family Physicians of Canada; 2020. Available from: https://patientsmedicalhome.ca/resources/best-advice-guides/the-patients-medical-neighbourhood/
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