Health Quality Ontario Home and Community Care Hospital Readmission

Best Practices

Updated on August 28, 2017

“By changing nothing, nothing changes.”

Tony Robbins

Percentage of new home care patients with unplanned hospital readmissions [http://indicatorlibrary.hqontario.ca/Indicator/Detailed/Hospital-readmissions-home-care-patients/EN] within 30 days after acute hospital discharge is a priority indicator for the QIP. This indicator measures the percentage of patients who were newly referred for home care services from the hospital that had unplanned hospital readmissions within 30 days of the initial hospital discharge. Generally, a lower percentage is better. In Ontario [http://www.hqontario.ca/System-Performance/Home-Care-Performance/Hospital-Readmissions] 11.6% of new home care patients were readmitted to the hospital within 30 days after discharge.

Below are best practices for reducing the percentage of new home care patients’ unplanned hospital readmissions. They are graded according to Type of Evidence [http://qualitycompass.hqontario.ca/Documents/EN/QualityCompassLevelsofEvidence.pdf]. Evidence-informed best practices are based on quality evidence, they can optimize outcomes and should be implemented into practice where possible.

To help you move from best evidence to best practice you can refer to HQO’s Best Path Transitions of Care Workbook [http://www.hqontario.ca/Portals/0/documents/qi/health-links/bp-improve-package-transitions-en.pdf] or the RNAO’s Care Transitions Clinical Practice Guideline [http://rnao.ca/bpg/guidelines/care-transitions].

EVIDENCE-INFORMED BEST PRACTICES

Recognition and Assessment

Evidence-Informed Best Practice	Change Ideas	Toolbox

Assess post-discharge risk and activate appropriate follow-up	• Use an evidence based risk assessment tool to assess rehospitalisation risk.
	• Follow up phone call within 48 hours of discharge.
	• Appointment booked with their primary care team 5 days post discharge.
	• Ontario Telemedicine Network or e-notification about discharged patients.
	• Post-transition phone calls and information using teach-back for those assessed as high risk for readmission.
	  ◦ How to recognize worsening symptoms
	  ◦ When and how to seek help, and from whom
	  ◦ When, how and why to take medications,
	  ◦ Scheduled appointments (when, where, why, and with whom)
	• Consider referring complex patients to Health Links
		• LACE Online risk assessment tool [http://hsprn.ca/lace2/lace_app_desktop.html]
		• LACE Tool [https://www.google.ca/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0ahUKEwj9k_6TktzVAhVI04MKHd-gBiQQFgg0MAI&url=http%3A%2F%2Fmicmrc.org%2Fsystem%2Ffiles%2FLACE_tool%2520word%25204.23.13.pdf&usg=AFQjCNHtTZMnXXCCWA1PkJel45apC2QvRA]
		• RNAO: Care Transitions Clinical Best Practice Guideline [http://rnao.ca/bpg/guidelines/care-transitions]
		• AHRQ Teach-back Method. [https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html]
		• Teach-Back Toolkit [http://www.teachbacktraining.org/]
		• Ontario Telemedicine Network [https://otn.ca/]
		• Health Links [http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx]

Self-Management and Patient Education

Evidence-Informed Best Practice	Change Ideas	Toolbox
Encourage Self-Management / Self-Care to avoid readmission. Involves educating people about their condition and care, motivating them to care for themselves better and tracking their progress.	• Patient and caregiver education programmes • Identify key family members/caregivers; consider them, along with the person, as "learners" and consider their level of health literacy. Use Teach-Back methods. • Use Healthlinks for better coordination. • Medication management advice and support. • Create an open environment and lines of communication for questions. Have in person conversations. • Psychological interventions and advice and support about diet and exercise (e.g., coaching) • Empower people/families to share in and manage their own health information and care plans and give them better access to their own records.	• Self-Management Program [http://www.swselfmanagement.ca/] • AHRQ Teach-back Method [https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html] • Teach-Back Toolkit [http://www.teachbacktraining.org/] • IHI "How To" Guide for Transitions [http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionsfromHospitaltoHomeHealthCareReduceAvoidableHospitalizations.aspx] • RNAO: Care Transitions Clinical Best Practice Guideline [http://rnao.ca/bpg/guidelines/care-transitions] • Self-Management Website [https://www.selfmanagementuk.org/] • Health Links [http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx] • Nesta People Powered Health [http://www.nesta.org.uk/project/people-powered-health] • Trust in the Doctor Patient Relationship [http://bmjopen.bmj.com/content/3/5/e002762.full]

Medication Reconciliation (Med Rec)

Evidence-Informed Best Practice	Change Ideas	Toolbox

Medication Reconciliation at Admission to Home Care	• Partner with your patient to create a complete and accurate list of medications 24-48 hours upon admission to home care
	  • Interview the patient and their caregiver
	  • Make note of ALL medications: name, dose, route and frequency
	  • Review a secondary source of information for the patient's medication
	• Identify and resolve any discrepancies in the list.
	• Document and record changes to medications
		• Ontario College of Pharmacists, Best Possible Medication History Tool. [http://www.ocpinfo.com/library/practice-related/download/Best%20Possible%20Medication%20History%20Form.pdf]
		• Vancouver Coastal Health MedRec. [https://bcpsqc.ca/documents/2012/09/Medication_Reconciliation_VCH-PHC-2011.pdf]
		• My Medication Reconciliation for Patients [https://www.knowledgeisthebestmedicine.org/index.php/en/medication_record].
		• Medication Reconciliation in Canada [https://www.accreditation.ca/sites/default/files/med-rec-en.pdf].
		• Home Visit Checklist for MedRec. [https://www.ncbi.nlm.nih.gov/pubmed/26323007]

The Physician's role in Medication Reconciliation	• Involve physicians in identifying their roles and determining appropriate workflow processes • Ensure proper support and tools are available to assist with the process • Encourage physicians to act as champions to demonstrate the importance of MedRec as a patient safety initiative	• ISMP/HQO Medication Reconciliation in Ontario. [https://www.ismp-canada.org/download/PrimaryCareMedRecGuide_EN.pdf] • Med Rec Ontario FAQ: coordinating medication in the community. [https://www.ismp-canada.org/download/MedRec/FAQ-coordinate-MedRec-community.pdf] • ISMP National Summit on Optimizing Med Rec at Transitions. [http://www.ismp-canada.org/download/MedRec/MedRec_National_summitreport_Feb_2011_EN.pdf] • HQO Reconciling Medication at key Transitions. [http://www.hqontario.ca/Portals/0/documents/bp/bp-webinar3-presentation-en.pdf]

The Pharmacist's and Pharmacy Technician's role in Medication Reconciliation	**Pharmacists** • Ensure dedicated pharmacy resources are available for MedRec during the planning stages • Involve pharmacists at all stages of MedRec • Ensure support and tools are available for the process **Pharmacy Technicians** • Assist in conducting accurate and complete best possible medication histories • Ensure proper support and resources are available to assist with the process	• Canadian Pharmacists Association Medication Reconciliation [https://www.pharmacists.ca/cpha-ca/assets/File/news-events/Medication%20reconciliation-a%20look%20within%20and%20beyond%20the%20hospital%20walls_Teo_Madorin.pdf] • Medication Reconciliation in Canada. [https://www.accreditation.ca/sites/default/files/med-rec-en.pdf]
Engage Senior Leadership in Medication Reconciliation	• Encourage senior leadership to identify MedRec as a strategic priority for the organization • Assume responsibility for providing the proper support and guidance to organizational employees	• Medication Reconciliation in Canada [https://www.accreditation.ca/sites/default/files/med-rec-en.pdf]. • ISMP Medication Reconciliation. [https://www.ismp-canada.org/medrec/]

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Measurement

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“While all changes do not lead to improvement, all improvement requires change”

Institute for Healthcare Improvement

How do we know if a change is an improvement? Measurement is a critical step in QI to assess the impact of a change. Quality indicators are used in the QIPs to measure how well something is performing. There are three types of quality indicators used to measure QI efforts:

- ***Outcome Indicators***: capture clinical outcomes and or system performance,
- ***Process Indicators***: track the processes that measure whether the system is working as planned, and
- ***Balancing Indicators***: ensure that changing one part of the system does not cause new problems in another.

Indicator	Percentage of new home care patients with unplanned hospital readmissions within 30 days after acute hospital discharge [http://indicatorlibrary.hqontario.ca/Indicator/Detailed/Hospital-readmissions-home-care-patients/EN]
Topic	Integration, Readmission
Quality Dimension	Effective
Type of Indicator	Outcome
Measure	Percentage (%)
Data Source	Discharge Abstract Database (DAD), Home Care Database (HCD), Registered Persons Database (RPDB)
Data Collection Instrument	Collected by the Institute for Clinical Evaluative Sciences (ICES)
How to Calculate	The percentage is calculated as: (Numerator/Denominator) x 100 **Numerator**: # of unplanned hospitalizations by home care patients newly referred to home care services within 30 days of initial hospital discharge. **Denominator**: # of patients newly referred to home care when discharged from hospital and received first home care service visit within the time period of interest.
Target	Lower is better
Range	0 – 100%
HQO Reporting Tool	Public Reporting, and Quality Improvement Plans (QIPs)

This data can be presented using Run Charts [http://qualitycompass.hqontario.ca/Documents/EN/Interpreting%20Run%20Charts.pdf] to track improvement over time. To read more about general measurement in QI refer to Measurement for Quality Improvement [http://www.hqontario.ca/Portals/0/Documents/qi/qi-measurement-primer-en.pdf] or the QI Getting Started Section [http://qualitycompass.hqontario.ca/portal/getting-started#.WZMhL1F96Uk].

Tools & Resources

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Transitions

- **AHRQ's Teach Back Method [https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2_tool5.pdf]**
- RNAO's Care Transitions: Clinical Best Practice Guidelines [http://rnao.ca/bpg/guidelines/care-transitions]
- **CIHI's All Cause Readmission to Acute Care and Return to the Emergency Department [https://secure.cihi.ca/free_products/Readmission_to_acutecare_en.pdf]**
- **Enhancing the Continuum of Care: Report of the Avoidable Hospitalization Advisory Panel [http://www.health.gov.on.ca/en/common/ministry/publications/reports/baker_2011/baker_2011.pdf]**
- **Health Quality Ontario's best PATH Transitions of Care Workbook [http://www.hqontario.ca/Portals/0/documents/qi/health-links/bp-improve-package-transitions-en.pdf]**
- Living a Healthy Life With Chronic Conditions: The South West Self-Management Program [http://www.swselfmanagement.ca/]
- **OHTAC Recommendation: Impact of Advanced (Open) Access Scheduling on Patients with Chronic Diseases (Draft) [http://www.hqontario.ca/en/mas/pdfs/2012/tech/AdvAccOHTACRecommendation20120807v08.pdf]**
- **Qmentum Quarterly: Quality In Health Care - Transitions in Care [http://qualitycompass.hqontario.ca/Documents/EN/Tools/Accreditation%20Canada%20Care%20Transitions%20Newsletter.pdf]**
- **"Teach Back": A Tool for Improving Provider-Patient Communication [http://www.ethics.va.gov/docs/infocus/InFocus_20060401_Teach_Back.pdf]**
- Care Team Connect [http://www.careteamconnect.com/]
- The Care Transitions Program® [http://www.caretransitions.org/]
- Hospital to Home [http://www.h2hquality.org/WebinarsToolsandSurveys/tabid/220/Default.aspx]
- IHI State Action on Avoidable Rehospitalizations (STAAR) [http://www.ihi.org/offerings/Initiatives/STAAR/Pages/default.aspx]
- Society of Hospital Medicine, BOOSTing Care Transitions [http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/06Boost/00_Boost.cfm]

Medication Reconciliation

- AHRQ's Match Toolkit [https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/match/index.html]
- Best Possible Medication History Tool [http://www.ocpinfo.com/practice-education/practice-tools/articles/medication-history-guidelines-medication-reconciliation/]
- Cross Country MedRec Check-Up [http://www.ismp-canada.org/medrec/map/]
- IHI's Tools and Resources for Medication Reconciliation [http://www.ihi.org/Topics/ADEsMedicationReconciliation/Pages/default.aspx]
- ISMP's Medication Reconciliation in Canada: Raising the Bar [http://www.ismp-canada.org/medrec/#tab3]
- MyMedRec – A Patient Medication Reconciliation Tool [http://www.knowledgeisthebestmedicine.org/index.php/en/app]

Background

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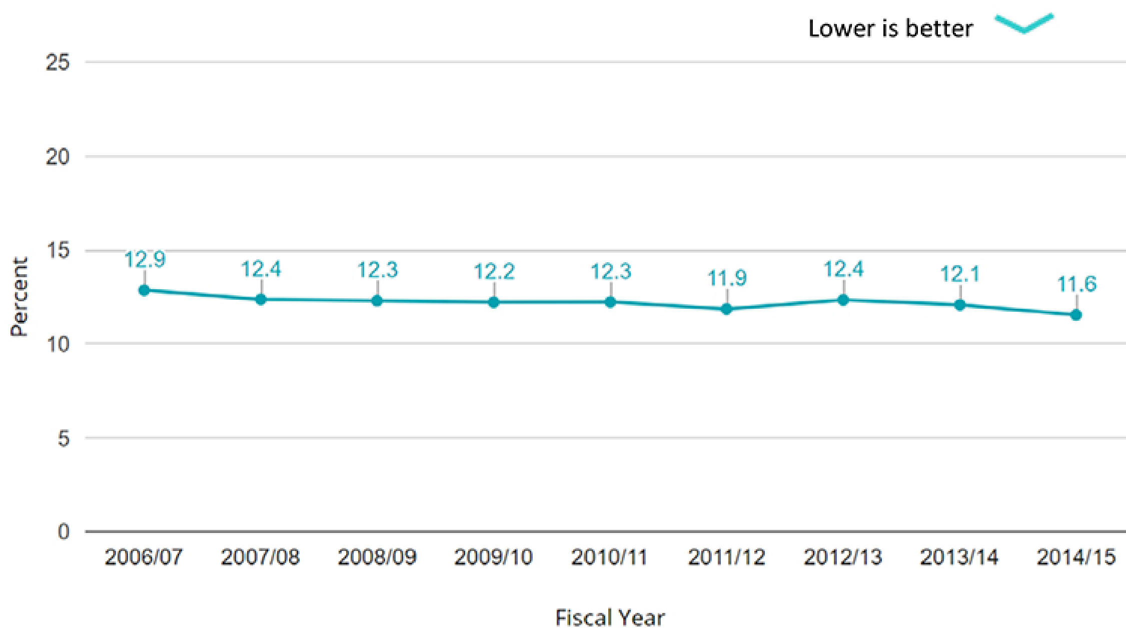
Issue

Sometimes patients need to be hospitalized again soon after being discharged from a previous hospitalization; this is called a readmission (HQO, 2015; 2017). Readmissions are sometimes unavoidable due to a worsening of the patient's condition unrelated to care. In other cases, readmissions indicate problems in the quality of care patients received, either while in hospital or during follow-up after leaving hospital. While this indicator does not give us an absolute picture of the readmissions due to inadequate care, improving or worsening performance does suggest improvement or worsening of the quality of care provided (HQO, 2015).

In Ontario, one of the key areas of focus in home care is reducing avoidable hospitalizations in order to provide the best quality and safety of health care for all Ontarians, and to optimize the use of health care resources (Baker et al. 2011). The overall percentage of new home care patients who return to hospital after being discharged is 11.6% (Figure 1).

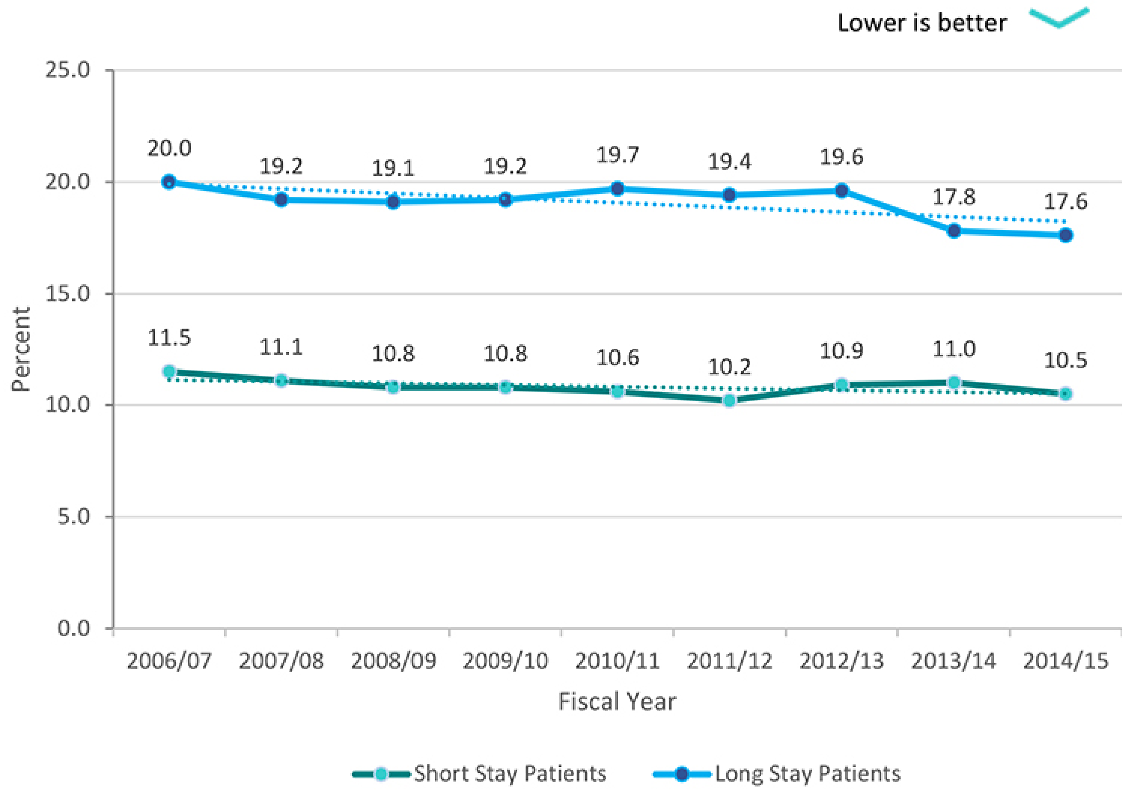
FIGURE 1: Percentage of new home care patients who return to hospital after being discharged, in Ontario, 2006/07 to 2014/15 - Overall



Source: Discharge Abstract Database (DAD), Registered Persons Database (RPDB), Home Care Database (HCD), provided by the Institute for Clinical Evaluative Sciences (ICES).

Readmission rates in Ontario have remained fairly stable over the last four years. The 30-day readmission rate for short stay patients was 10.5% in 2014/15 and for long stay patients, the readmission rate was 17.6% (Figure 2).

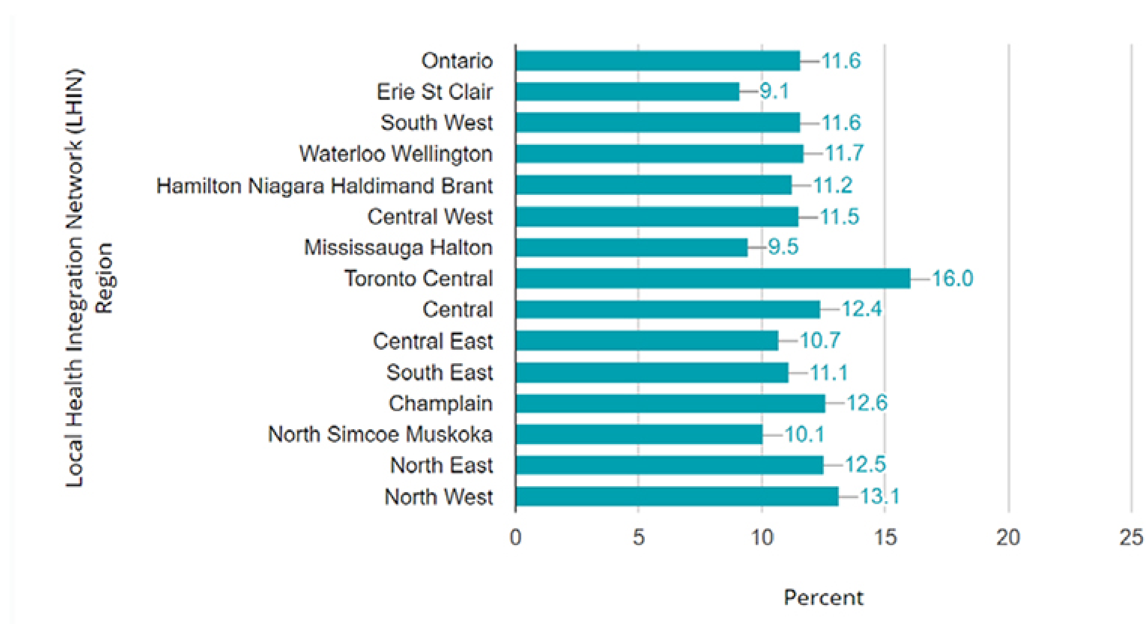
FIGURE 2: Percentage of new home care patients who return to hospital after being discharged, in Ontario, 2006/07 to 2014/15 - Short stay and Long stay Patients



Source: Discharge Abstract Database (DAD), Registered Persons Database (RPDB), Home Care Database (HCD), provided by the Institute for Clinical Evaluative Sciences (ICES).

Across Ontario's LHIN regions there is substantial variation in return to hospital after discharge during the 2014/15 fiscal year (Figure 3). Toronto Central has the highest percentage of overall new home care patients who return to hospital after being discharged.

FIGURE : Percentage of new home care patients who return to hospital after being discharged, in Ontario, by LHIN region, 2014/15 - Overall



Source: Discharge Abstract Database (DAD), Registered Persons Database (RPDB), Home Care Database (HCD), provided by the Institute for Clinical Evaluative Sciences (ICES).

Call to Action

Providing safe and effective **transitions** in care is an important strategy for minimizing unnecessary hospitalizations and ED visits, and reducing avoidable readmissions of patients discharged from hospital to the community (Baker et al. 2011; HQO 2015; Jones et al. 2016). A care transition is the transfer of a patient between different settings and health care providers during the course of an acute or chronic illness (HQO, 2015). Some key transition points include preparing for discharge, discharge, primary care, community care, and self-care follow-up. Risk factors of readmission vary based on patient factors, hospital, region and country and many of them can be avoidable (Jones et al. 2016; Mahmoudi et al. 2016; Naylor 2011). However, usually people are readmitted to hospital during the first 30 days following discharge because of:

- Unclear or delayed discharge plan and instructions
- Conflicting plans and instructions from different providers
- Medication errors, including dangerous drug interactions and duplications.

Hospital readmission has a high burden on both health care systems and patients. Most readmissions are thought to be related to the quality of the health care system (HQO 2015; Mahmoudi et al. 2016). Improving discharge planning, recognition and assessment, patient education, and follow up communication has been shown to reduce readmissions (HQO 2017; Jones et al. 2016; Phillips 2014; Goncalves 2016).

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