HEALTH QUALITY ONTARIO'S
Quality Compass
Navigate from knowledge to action

Ontario
Health Quality Ontario
Qualité des services de santé Ontario

Health Quality Ontario
Primary Care
Post-Discharge Follow-Up

Overview

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Issue

Facilitating effective transitions within Ontario's healthcare system helps to provide the best outcomes for patients as they move through the different levels of care. Primary care follow-up after a hospitalization has been shown to provide better continuity of care and reduce readmissions to hospitals for patients with multiple conditions or complex needs[1,2]. In 2012, 30-day readmission rates for patients treated for heart failure was 21% while chronic obstructive pulmonary disease patients was 19%[3]. Less than half of these patient populations were found to be receiving follow-up appointments within the target 7 days[4]. This creates a gap in the patient's care and increases the risk for a readmission, and increases the burden on the healthcare system[1,2,4].

Call to Action

The post-discharge period is a potentially vulnerable transition point for patients. Greater cross-sector collaboration is necessary to provide a seamless care transition. In 2014/15, less than half of the patients hospitalized for heart failure or chronic obstructive pulmonary disease saw their family doctor or specialist within seven days of discharge[4]. This rate has remained stable in recent years and shows great variation across the province[4].

References

1. **Hernandez AF, Greiner MA, Fonarow GC, Hammill BG, Heidenreich PA, Yancy CW, Peterson ED, Curtis LH.**

   Relationship between early physician follow-up and 30-day readmission among Medicare beneficiaries hospitalized for heart failure. JAMA. 2010. May;303(17):1716-22.

2. **Health Quality Ontario & Ministry of Health and Long-Term Care**

   Quality-Based Procedures: Clinical Handbook for Chronic Obstructive Pulmonary Disease (Acute and Postacute).
   Available from: http://health.gov.on.ca/en/pro/programs/ecfa/docs/qbp_copd.pdf [http://health.gov.on.ca/en/pro/programs/ecfa/docs/qbp_copd.pdf]

3. **Canadian Institute for Health Information**

   All-causes readmission to acute care and return to the emergency department. 2012.
   Available from: https://secure.cihi.ca/free_products/Readmission_to_acutecare_en.pdf [https://secure.cihi.ca/free_products/Readmission_to_acutecare_en.pdf]

4. **Health Quality Ontario**

   Measuring Up. 2016.
   Available from: http://www.hqontario.ca/portals/0/Documents/pr/measuring-up-2016-en.pdf [http://www.hqontario.ca/portals/0/Documents/pr/measuring-up-2016-en.pdf]

Best Practices

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"Insanity is doing things the way we've always done them and expecting different results"

Albert Einstein

Evidence-informed best practices are based on quality evidence and should be implemented into practice to optimize outcomes. Listed below you will find best practices graded according to the type of evidence. To view a description of the types of evidence, **click here**.

To help you move from best evidence to best practice, **click on the + button next to each best practice** to find details on how to implement, as well as change ideas to test using a PDSA approach.

Change ideas are specific and practical changes by experience and research that focus on improving specific aspects of a system, process or behaviour. To learn more about change ideas see the QI: Getting Started Section. [http://qualitycompass.hqontario.ca/portal/getting-started]

EVIDENCE-INFORMED BEST PRACTICES

Notification of Patient Admission to Hospital

Access Timely Information from Hospital Discharge

Patient and Caregiver Education

Scheduling Follow-up Appointment before Discharge

References

1. Quality Based Procedure Handbooks [http://www.health.gov.on.ca/en/pro/programs/ecfa/funding/hs_funding_qbp.aspx] - Ministry of Health and Long-term Care
2. Alternate Level of Care. 2016. Cancer Care Ontario. Available from: https://www.cancercare.on.ca/ocs/alc/ [https://www.cancercare.on.ca/ocs/alc/]
3. Your Health System. Canadian Institute for Health Information 2016. Available from: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/theme/C5001/2/N4IgWg9gdgpgljALgQwJYBsDOBhRAndEALIBgA8AHZKAExhuPwFcYBfVoAA [https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/theme/C5001/2/N4IgWg9gdgpgljALgQwJYBsDOBhRAndEALIBgA8AHZKAExhuPwFcYBfVoAA]
4. Alternate Level of Care (ALC) - September 2016. Access to Care. Cancer Care Ontario. Available from: http://www.oha.com/News/Documents/ALC%20Report%20-%20September%202016.pdf [http://www.oha.com/News/Documents/ALC%20Report%20-%20September%202016.pdf]
5. Measuring Up - 2016. Health Quality Ontario. Available from: http://www.hqontario.ca/portals/0/Documents/pr/measuring-up-2016-en.pdf [http://www.hqontario.ca/portals/0/Documents/pr/measuring-up-2016-en.pdf]
6. Mekonnen AB, McLachlan AJ, Brien JA. 2016. Effectiveness of pharmacist-led medication reconciliation programmes on clinical outcomes at hospital transitions: a systematic review and meta-analysis. BMJ Open 6(2):e010003 2016 Feb. 23
7. Priority Assistance to Transition Home (PATH) Program [http://nnpcn.com/wp-content/uploads/2013/05/PATH-one-pager-ssm-april-2013.pdf] - Canadian Red Cross / North East LHIN
8. Meldon, S. W., Mion, L. C., Palmer, R. M., Drew, B. L., Connor, J. T., Lewicki, L. J., Bass, D. M. and Emerman, C. L. (2003), A Brief Risk-stratification Tool to Predict Repeat Emergency Department Visits and Hospitalizations in Older Patients Discharged from the Emergency Department. Academic Emergency Medicine, 10: 224–232. Available Here [https://www.ncbi.nlm.nih.gov/pubmed/12615588]
9. Patient Flow Toolkit [http://hqc.sk.ca/Portals/0/documents/Patient%20Flow%20Toolkit%20April%202016.pdf?ver=2016-05-05-093704-600] - Saskatchewan Health Quality Council

Measurement

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"Some is not a number, soon is not a time."

Don Berwick, former President and CEO of IHI, December 2004, at launch of the 100,000 Lives Campaign

How will we know if a change is an improvement? Measurement is one of the critical steps in a quality improvement (QI) initiative that assesses the impact of your tests of change. **Quality indicators** are used to measure how well something is performing. There are three types of quality indicators used to measure your QI efforts: **outcome** (indicators that capture clinical outcomes and or system performance), **process** (indicators that track the processes that measure whether the system is working as planned), and **balancing** indicators (indicators that ensure that changing one part of the system does not cause new problems in other parts of the system).

Type of Indicator	Indicator of Quality Improvement	How to Calculate: numerator _____ denominator	Targets/ Benchmarks	How is This Indicator Used?
Outcome	Percentage of patients or clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	See Indicator Library [http://indicatorlibrary.hqontario.ca/Indicator/Summary/7-day-post-hospital-discharge-follow-up-selected-condition/EN]	Targets: As high as possible (set by individual practices)	QIP Priority Indicator
Outcome	Percentage of patients who were discharged in a given period for a condition within selected HBAM Inpatient Grouper HIGs and had a non-elective hospital readmission within 30 days of discharge, by primary care practice model.	See Indicator Library [http://indicatorlibrary.hqontario.ca/Indicator/Summary/Hospital-readmission-rate-primary-care-patient-QIP/EN]	Targets: As high as possible (set by individual practices)	QIP Additional Indicator

Tools & Resources

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Resources

- How-to Guide: Creating an Ideal Transition Home [http://www.hqontario.ca/portals/0/Modals/qi/en/processmap_pdfs/tools/ihi_how_to_guide_creating_an_ideal_transition_home.pdf]
  - Institute for Healthcare Improvement
- Adopting a Common Approach to Transitional Care Planning: Helping Health Links improve Transitions and Coordination of Care [http://www.hqontario.ca/Portals/0/documents/qi/health-links/bp-improve-package-traditional-care-planning-en.pdf]
  - Health Quality Ontario
- Transitions Between Hospital and Home: In the Community post Hospital Stay [http://www.hqontario.ca/Portals/0/documents/qi/health-links/ensure-discharge-summary-available-within-hours-en.pdf]
  - Health Quality Ontario
- Transitions Between Hospital and Home: Close to Time of Discharge [http://www.hqontario.ca/Portals/0/documents/qi/health-links/ensure-discharge-summary-available-within-hours-en.pdf]
  - Health Quality Ontario

QI Tools

- Communications Plan: **Instructions** , **Tool**
- Fishbone Template: **Instructions** , **Tool**
- Five Whys: **Instructions** , **Tool**
- Measurement Plan Template: **Instructions** , **Tool**
- Pareto Chart: **Instructions** , **Tool**
- **PDSA Template**
- **Project Charter**
- Tree Diagram **Worksheet**

For a more comprehensive list of tools and resources, visit the following links on our HQO website:

- HQO Tools and Resources [http://www.hqontario.ca/quality-improvement/tools-and-resources/]