



Quality improvement project triggers changes to help patients move from hospital to 'home' with more ease and better services

Patients/caregivers shed light on challenges; community care partners already acting on input

(Toronto, October 28, 2009) - A project in two regions of the province that captured the experiences and challenges of elderly patients moving from hospital to home or long-term care has already precipitated changes to improve those transitions.

Having Their Say and Choosing Their Way: helping patients and caregivers move from hospital to 'home', was funded by The Change Foundation in partnership with the Ontario Association of Community Care Access Centres (OACCAC). It was conducted in the South East CCAC and Quinte Health Care's Trenton Memorial Hospital in 2008 and in Toronto Central CCAC and Toronto Western Hospital in 2009. Reports on the project are being released today at www.changefoundation.com, along with a [Commentary](#) by The Change Foundation, informed by insights from project partners and highlighting changes implemented since the project wrapped up.

The research findings came from interviews conducted with 30 recently discharged patients and their caregivers and from observations drawn from shadowing key staff, tracking and analyzing the myriad steps in the trek from hospital to home, with services, or from hospital to long-term care. *Having Their Say & Choosing Their Way* is a quality improvement project so it focused on opportunities for improvement, not on all the successful transitions that occur each year. While patients and their families praised some providers and were grateful for the care, others found it unhelpful or insufficient. Many reported they were confused about the next steps in their care and uncertain where to turn for help, ill-informed about who would provide what services when, and unclear about the rules for placement in long-term care facilities. "It's sort of like a black hole you know," said one patient.

"The Change Foundation invested in this project because timely, supportive transitions from hospital to "home" are key to high quality, efficient health care. The Foundation is also committed to looking at quality improvement through the eyes of patients and caregivers, and we've learned from their real-life stories that many of our efforts aren't paying off for them – or the system," said Change Foundation CEO Cathy Fooks. "We will use this work to redirect and redesign appropriate care around the particular needs of patients as they leave hospital and get on with their lives," says OACCAC CEO Margaret Mottershead.

The good news, says Fooks, is that the project is already having on-the-ground impact for patients, families and providers and points to ways to help alleviate systemic issues such as avoidable ER admissions and unnecessary hospital stays or alternate-level of care (ALC) days. "We commend the site partners for their commitment to quality improvement, patient input and

public scrutiny to drive changes to support Ontarians in the midst of these life-changing transitions,” say Fooks and Mottershead.

“This project, combined with others, was pivotal for the Toronto Central CCAC in challenging our thinking and behaviours,” says Stacey Daub, Senior Director, Client Services from the Toronto Central CCAC. “It brought the voice of the client to our planning and it significantly informed our path forward. We have dramatically changed our approach to transitions with our hospital partners as a result.”

“The study reminded us that we are caretakers of peoples’ live and futures,’ says Katherine Stansfield, VP, Patient Services, Quinte Health Care. “Each part of the system is responsible for a segment of the process, but it’s a person’s life we’re affecting. We can’t lose sight of that in the midst of stats and aggregate numbers.”

Key project findings based on patient input and process analysis

Common challenges

- Patients are remaining in hospital when they should be receiving care elsewhere.
- Patients/caregivers need more face-time with key staff to navigate a complex, confusing system – in a 20-step process, only two involved time with the patient.
- Patients are often unclear about the central, coordinating role of the CCAC and how to access services.
- There is a need for more proactive community placement planning, greater coordination and information sharing among providers working across the system, more consistent, patient-friendly communication.

Hospital to home journey

- People going home with home care lack clear and complete information to help them understand what is available to help them when they get home. “I don’t know” was a common refrain from patients/families when asked about their service status.
- Patients were grateful for home-care services and appreciated personal attention by staff and communication in their own language (especially important in multi-ethnic Toronto).
- There was sometimes a mismatch between the timing and type of home-care services and what help people needed most at home.
- There were 247 steps in the hospital-to-home process, using nine databases, 35 forms/tracking sheets/brochures; 11 handoffs/waits for patients (among staff/between steps).

Hospital to long-term care journey

- Patients and caregivers felt rushed in reaching life-changing decisions based on ‘best guess’ information in a process that lacked transparency, clarity, and ownership.
- There is little understanding among patients about their relative position on a wait list, how much time they have to wait, and what moves people higher on the waiting list for an available bed; patients are confused about the rules governing hospital discharge.
- Care options – including supportive housing, home care, and long-term care – are not systematically offered. Once labelled “ALC”, patients receive information that is heavily oriented to long-term care choices.

- There were 160 steps in hospital-to-long-term care process, using nine databases, 36 forms, and 15 handoffs/waits for patients (among staff/between steps).

Project Impact – and changes across the system:

The reports include many suggestions to improve the transition process and experience for patients, caregivers and providers, especially for those with complex health-care needs such as seniors. The hospital and CCACs involved in the project – and other organizations across the system -- have already taken big and small steps to improve how they organize and deliver care and communicate with patients and their families. Among them:

- The Toronto Central CCAC is assigning care coordinators who are responsible for a smaller number of clients with complex needs rather than carrying a generic caseload. This wrap-around support model for high-risk populations – seniors, children and adults with medically complex needs -- provides much more intensive support and follows the client across the continuum.
- Quinte Health Care and Toronto Western Hospital have CCAC case managers on site and in the ED to help provide consistent coordination for post-acute patients.
- The OACCAC is working with CCACs to implement a common Client Health and Related Information System (CHRIS) to develop common assessment tools and automate a significant amount of the paperwork. This provides more time with clients and a quicker start to treatment. Hospitals and EDs will also have access to a list of CCAC clients so they can notify the CCAC when one of them goes to the ED or is admitted. CCACs also receive automatic referrals from hospitals when patients being admitted meet certain criteria (over 75 with a chronic condition.)
- Programs (called Home First in Mississauga Halton and Waiting at Home across Toronto) that bring people home from acute care with supports while waiting for long-term care or deciding on next steps are seeing drops in long-term care placements.
- SE CCAC has introduced and resourced a review to ensure “client value” is part of all processes.

For more on the project, read the detailed project reports and The Change Foundation’s Commentary at www.changefoundation.com

The Change Foundation is an Ontario health policy think tank that generates research, analysis and informed discussion on health system integration and quality improvement in home and community care.

The OACCAC is a voluntary organization that represents Ontario’s Community Care Access Centres.

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