Bridge-to-Home BC & Yukon

A BCPSQC & HEC Partnership

Call for Applications

Submission Deadline:
September 09, 2022

Submit to:
bridgetohome@bcpsqc.ca

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Healthcare Excellence Canada works with partners to spread innovation, build capability and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaboration with patients, caregivers and people working in healthcare, HEC turns proven innovations into lasting improvements in all dimensions of healthcare excellence. Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement.

The **BC Patient Safety & Quality Council** is an independent public body that works to better the health care for all British Columbians. BCPSQC delivers the latest knowledge from home and abroad to champion and support high-quality care for every person in our province. This system-wide impact requires creativity and innovative thinking, which we combine with evidence-informed strategies to shift culture, improve clinical practice and accelerate our partners' improvement efforts.

BCPSQC also understands that meaningful change comes from working together and is uniquely positioned to build strong partnerships with patients, care providers, health leaders, policymakers, senior executives, academics and others. These connections enable BCPSQC to nurture networks, recognize the needs of BC's health care system and build capacity where it is needed the most.

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Acknowledgement

We acknowledge that the Vancouver office of the BC Patient Safety & Quality Council is located on land which is the unceded territory of the Coast Salish peoples, including the territories of the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and səl̓ilwətaʔɬ (Tsleil-Waututh) Nations, with staff and support from many communities across what is known today as British Columbia.

Healthcare Excellence Canada honours the traditional territories upon which our staff and partners live, work and play. We recognize that the stewardship of the original inhabitants of these territories provides for the standard of living that we enjoy today.

Language Matters

This form aims to assist with fostering and maintaining good relations with others using words and phrases that are respectful, inclusive (rather than potentially stigmatizing) and accurately represent people. Language throughout this document incorporates an equity lens, the Government of British Columbia's Declaration on the Rights of Indigenous Peoples Act and the provincial Commitment on Cultural Safety and Humility in Health Services.[1]

[1] BC Centre for Disease Control (BCCDC) COVID-19 Language Guide. July 2020. Retrieved from: http://www.bccdc.ca/Health-Info-Site/Documents/Language-guide.pdf

Call for Applications

The BC Patient Safety & Quality Council (the Council) is partnering with Healthcare Excellence Canada (HEC) to deliver the Bridge-To-Home BC & Yukon Collaborative. Interested teams from across British Columbia and the Yukon are welcome to submit an Expression of Commitment. This quality improvement initiative focuses on improving care transitions from hospital to home and community through the implementation of a **patient-oriented care transitions bundle.** The bundle includes:

- a Patient-Oriented Discharge Summary (PODS)
- use of 'teach-back' methods for patient and care partner education
- involvement of patients and care partners in discharge processes
- post-discharge follow up.

Participating health authorities are **eligible for up to $40,000 in seed funding**, coaching, and numerous learning and networking opportunities for a team or multiple teams (comprised of patient and care partner advisors, providers and leaders from hospitals, home and community organizations) to support the design, implementation and evaluation of this initiative.

The goals of the collaborative are to:

- Improve the patient and care partner experience of transitions from hospital to home/community care
- Improve the confidence of patients and care partners to manage their care as they transition to home
- Improve provider experience of care
- Reduce avoidable hospital readmissions
- Enhance the capacity of improvement teams to engage with patients and care partners as integral team members throughout the quality improvement process.

This collaborative will advance the shared priority of enhancing home and community care by spreading evidence-based innovations that provide patients and care partners with the knowledge and confidence they need to manage their care at home or in the community.

How to Apply

- Step 1: Send an email to bridgetohome@bcpsqc.ca by August 5, 2022 to express your interest in this collaborative. This should be a primary point of contact and include any early team members.
- Step 2: We will connect with you to set up a pre-application call, as well as send you the full Expression of Commitment and Readiness to Receive Assessment forms.
  - We want to support you throughout the application process. During the pre-application call we will go over the application process, submission requirements, and program timelines and expectations.
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Bridge-to-Home Overview

The Issue

Throughout their lives, patients move through the health system with different healthcare teams in varied settings and, together with their care partners, they are the one constant throughout the journey. Making care seamless for patients using an integrated model to support continuity remains a goal in the provision of high-quality care. There have been pockets of success emerging across Canada, as service delivery organizations test different models to wrap services around the patient, using a variety of funding, policy, and organizational levers to bundle health and social services across multiple providers and sectors.[1] However, such care is not yet the norm in Canada, and silos that do not support patients and their care partners as they navigate through this complex system continue to exist.

Transitions from hospital back into the community can be particularly challenging and pose potential risk for patients as a time of significant stress and negative experiences of care.[2] Evidence demonstrates that transitions in care may result in adverse events and suboptimal patient outcomes, emergency room visits, or hospital readmissions.[3, 4, 5] In Canada, approximately 8.5% of adult acute care patients were readmitted to an acute care hospital within 30 days of their initial discharge, costing an estimated $1.8 billion and accounting for 11% of all acute hospital costs.[6] While not all readmissions are avoidable, research suggests between 9% and 59% of readmissions may be prevented.[6]

Although all Canadian accredited hospitals have elements of discharge planning in place, inconsistent practices and processes, limited resources, and lack of coordination within and across providers and organizations, often leave patients confused and unsure of what to expect when they transition to home.[2] In particular, poor communication with patients and care partners at discharge has been noted as an important care gap. Patients may not understand medical terms, may not be fluent in English, and may have difficulty retaining verbal instructions. Additionally, they may be too stressed at the time of illness to absorb the information, all of which can contribute to a lack of confidence in their ability to manage care on their own.[2, 7, 8] Traditional discharge summaries are laden with clinical information designed for provider to provider communication, and not geared to provide patients with information they require to manage their care at home.

Many patients may not have someone to support their care at home. For those who do, family or friends are often not engaged by healthcare providers in the care of their loved ones while in hospital.[2, 9] This again represents a gap, as many family and friends assume more significant responsibilities for care as primary caregivers once their loved one is discharged from hospital and returns home.[8] Failure to acknowledge and build on the expertise of patients and caregivers is a missed opportunity at best, and at worst, can result in a perilous return home.

About Improving Care Transitions

Transitions in care are defined as "a set of actions designed to ensure the coordination and continuation of health care as patients transfer between different locations or between levels of care within the same clinical setting."[10, 11]

Patients experience transitions at many points in their journey through the health system. What we know from patients is that key elements such as receiving adequate, relevant, actionable information is crucial to making this change as seamless as possible.[12, 8] The specific transition from hospital to home has been well-studied. A recent systematic review conducted by Burke and colleagues[4] identified 10 domains of an "ideal transition" from hospital to home that would decrease rates of hospital readmissions. This "bridge model" is anchored at one end by care teams within institutions, and at the other end by care teams in the community. The "bridge" requires collaboration between sectors, and importantly, engaging patients and care partners in the process. Using a multi-pronged approach to address the domains identified has shown promise in achieving improvements in the patient experience of transitions and patient outcomes, as well as decreasing readmissions to hospital.[4, 13] The domains are:

- discharge planning
- complete communication of information
- availability, timeliness, clarity and organization of information
- medication safety
- educating patients to promote self-management
- enlisting help of social and community supports
- advance care planning
- coordinating care among team members
- monitoring and managing symptoms after discharge
- outpatient follow up.

The Innovation: A Patient-Oriented Care Transitions Bundle

Improvement teams designing and implementing the following interventions will need to understand what matters most to their patient populations, using a variety of engagement methods. Having patients and care partners as members of the improvement team will provide different insights and new ideas to improve care delivery.

1. The Patient-Oriented Discharge Summary (PODS)

The University Health Network's (UHN) OpenLab (uhnopenlab.ca) co-designed the PODS tool together with patients and care partners. PODS engages patients and care partners in collaborative discharge planning to ensure they consistently receive information they need to effectively manage their health as they transition to home. This tool is adaptable to many different settings. It provides a written, easy-to-understand, template with information that patients and care partners have said they want and need in order give them confidence in their care transition. This information includes:

- instructions on medications
- activity and diet restrictions
- follow-up appointments
- expected symptoms following discharge and worrisome symptoms warranting further attention
- contact information for providers should they have further questions

PODS has been adapted and implemented with many patient populations, both paediatric and adult, across different health sectors. Improvement teams that include patients and care partners will adapt the PODS tool to reflect what is important to their specific patient populations to deliver patient-oriented discharge summaries.

2. Effective Patient and Care Partner Education

Education to prepare patients and care partners for home is essential and is a core element of the implementation process for PODS. Teach-back is one evidence-informed education strategy used to involve patients in their care by asking them to state, in their own words, what they need to know about their health and how to manage their care.[14] Using teach-back improves patient knowledge of their condition, patient adherence to the treatment plan and self-efficacy in managing their care.[7] Improvement teams in the collaborative will adopt effective education strategies such as teach-back method in the delivery of their

PODS intervention to improve patient and care partner understanding about their health condition and perceived self-efficacy in managing their condition when they return home.

3. Welcoming Family / Friends as Partners in Care

For those patients fortunate to have care partners at home, they are allies for quality and safety and play a vital role in monitoring and assisting patients in managing medical, social, psychological and mental health needs.[13] Welcoming care partners – as defined by the patient – as partners in care in hospital 24/7 provides opportunities for them to be present throughout the care episode, and to be recognized as full participants in the circle of care. Care partner participation in team rounds, patient and care partner education, and discharge planning strengthens the ability of care partners to take on the role of primary caregiver following discharge.[2] A recent review by Rodakowski and colleagues[15] found that discharge planning interventions involving care partners were associated with positive results including decreased readmissions, shorter rehospitalizations and lower costs of post-discharge care. Teams in the collaborative will identify opportunities to welcome care partners as members of the care team at key times to strengthen the continuity of care (e.g. by ensuring 24/7 access to the patient; where possible, inclusion during admission processes, involvement at interprofessional rounds or shift report at the bedside, education, and in all aspects of discharge planning).

4. Post-Discharge Follow-Up

Patients and care partners often experience challenges in knowing where and how to access care after discharge, and to carry out instructions provided at discharge.[2, 16] While post-discharge follow-up methods continue to be tested and have demonstrated mixed results,[17] there is evidence to support how post-discharge telephone calls and home visits have identified safety issues in the home.[5] As well, there is evidence to suggest that such methods, as well as timely follow up with primary care have led to improvements in patient experience, and their understanding of the treatment, compared to patients who did not receive post-discharge support.[18, 19, 20] Improvement teams are strongly encouraged to seek out partnerships between organizations (institutions, home and community organizations) to improve information exchange between care settings and to establish interventions that support patients and care partners following discharge (e.g. home visits, follow-up calls after discharge) based on patient needs and risk.

Areas of Focus for Care Transitions

The care transitions bundle has been adapted to fit contexts in many different areas of care, including acute care, outpatients, rehabilitation, emergency care, and primary care settings, as well as with different patient populations, such as those in ICU, cardiac care, general medicine, stroke, substance use and in partnership with different communities (e.g. Chinese community organization).

The innovators of the original 'Patient-Oriented Discharge Summary' (PODS) at Open Lab-UHN have also supported organizations across all regions of Ontario to adapt and implement PODS in a wide-range of areas of care and with different patient populations (see PODS | A toolkit to create your own patient-oriented discharge summary – uhnopenlab.ca) for examples) and have demonstrated improvements in patient outcomes (see Research | PODS (uhnopenlab.ca)).

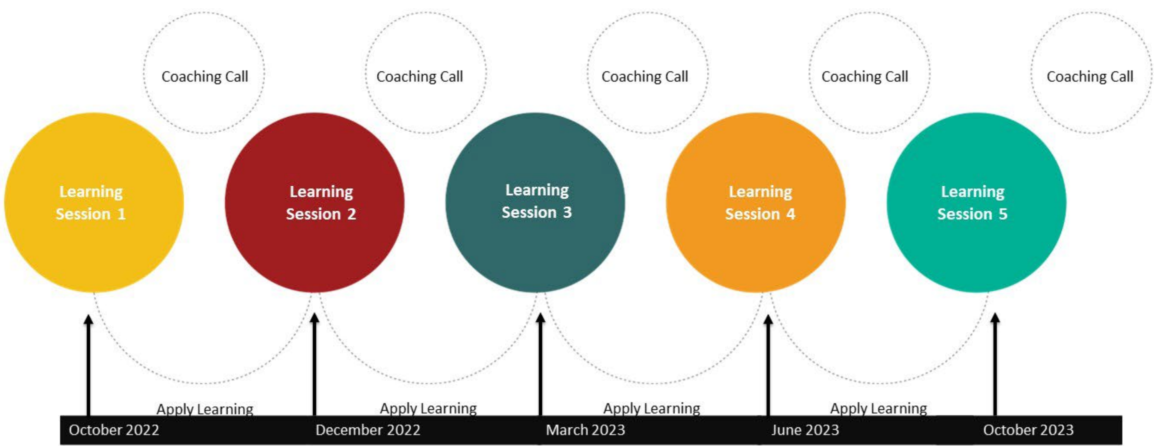
The BC & Yukon Collaborative

What is a Collaborative?

Collaboratives are quality improvement (QI) initiatives that bring together interprofessional teams to address a common healthcare issue through a team-based quality improvement project and shared learning. Collaboratives support teams to create or strengthen the quality improvement culture within their organization and support the implementation of innovations by providing seed funding, an evidence-informed quality improvement model, and coaching and advisory services.

Learning Modules

The collaborative will offer a combination of interactive webinars (via Zoom) and (potentially) in-person sessions, to share knowledge and techniques on a specific topic into everyday practice. Each period (of project work) helps translate theory into practice. The collaborative will take place over five modules delivered over the course of a year (dependent on COVID-19 pandemic status). Each module kicks off with a learning session which provides participants with new learning, ideas, connections and/or inspiration on a specific goal for the overall Bridge-to-Home program. The rest of the module is dedicated to time to apply that learning through recommended activities, connecting with other participants and coaching support from the BCPSQC and expert advisory team.



Measurement and Evaluation

Improvement teams may be required to collect and report on process and outcome measures to assess the impact of a patient-oriented care transitions bundle and the engagement of patients and care partners in redesign efforts. The BCPSQC and HEC will work together with teams to develop a core set of measures for all teams in the collaborative. In addition, teams may be supported to develop other indicators relevant to their specific initiatives and contexts.

Outcomes

Healthcare Excellence Canada hosted a pan-Canadian Bridge-to-Home spread collaborative (2018-2020) with 16 teams. Most teams were networks consisting of a healthcare institution (e.g. hospital, outpatient setting) together with a community, homecare organization or primary care network that would be supporting patients upon discharge. Some were based on a shared focus of care within a region (e.g. three organizations within a region focused on mental health transitions with one team member who played a coordinating function across sites).

Overall, teams in the pan-Canadian Bridge-to-Home collaborative indicated that they fully or partially improved the experience of care transitions, as well as the confidence of patients/care partners as they transitioned home. Some teams found improved provider experience of care and reduced avoidable readmissions. Teams enhanced their capacity for meaningful engagement with patient partners and others with lived experience for improvement. Teams with increased readiness for engagement were able to move more quickly into their change initiatives to adapt and implement the care transitions bundle.

Benefits of Participating in the Collaborative

Healthcare jurisdictions and accrediting bodies have increasingly focused on the patient experience of care. The Bridge-to-Home collaborative seeks to improve the patient and care partner experience as they transition from hospital to home by implementing a patient-oriented bundle that has been co-designed with patients and care partners to meet their needs. This collaborative will provide a common framework to strengthen connections between institutional care, patients and care partners, and community/ primary care/ home care. Interventions will be tailored by each improvement team based on the context and needs of their patients and care partners, and in alignment with

organizational priorities. Working together using an all-teach-all-learn approach, improvement teams will enhance their capacity to partner with patients and care partners and improve transitions using a quality improvement methodology. The collaborative will also enhance capacity for improvement teams to implement future quality improvement projects and to do so with patients and care partners. Improvement teams will also have access to a range of valuable resources to help organizations spread their improvement beyond their initial site(s). These resources include:

- Seed funding of up to $40,000 per improvement team
- Support to develop partnership models that include patients and care partners for quality improvement
- Support for the implementation and spread of a patient-oriented transition bundle
- Support for performance measurement and evaluation
- Peer-to-peer networking and exchanges
- Educational webinars focused on patient-oriented care transitions, patient engagement for quality improvement, improvement methodology, and change management
- In-person and/or virtual workshop(s) to foster cross-team learning (TBC)
- A network of expert faculty and coaches

Key Dates

Application Process

- Call for applications: July 2022
- Pre-Application Calls: August 2022
- Application deadline: September 09, 2022
- Notify all teams of acceptance into the collaborative: September 23, 2022
- Sign tri-partite agreements: September - October 2022

Collaborative Learning Series

- October 2022: Learning Module 1
- December 2022: Learning Module 2

- March 2023: Learning Module 3
- June 2023: Learning Module 4
- October 2023: Learning Module 5

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Appendix A: References

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