BRIDGE-TO-HOME SPREAD COLLABORATIVE:

PARTNERING WITH PATIENTS AND CAREGIVERS TO IMPROVE QUALITY AND PATIENT EXPERIENCE THROUGH CARE TRANSITIONS

PROSPECTUS

Canadian Foundation for Healthcare Improvement

Fondation canadienne pour l'amélioration des services de santé

cfhi-fcass.ca

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The Canadian Foundation for Healthcare Improvement is a not-for-profit organization funded by Health Canada. CFHI identifies proven innovations and accelerates their spread across Canada by supporting healthcare organizations to adapt, implement and measure improvements in patient care, population health and value for money.

The views expressed herein do not necessarily represent the views of Health Canada.

EXECUTIVE SUMMARY

> "When you are leaving the hospital, you are thrust into a situation where you are nervous and vulnerable. Having the correct understanding of my condition and a care action plan is essential for me to confidently manage my care and maintain my quality of life."

Sue Johnson, patient advisor

The Canadian Foundation for Healthcare Improvement (CFHI) is launching a new, 17-month spread collaborative to improve the quality of care and patient and caregiver[1] experiences of care during transitions from hospital to home. Using a quality improvement (QI) approach, improvement teams – comprised of patient and caregiver advisors, providers and leaders from hospitals, home and community organizations – will implement a patient-oriented care transitions bundle that focuses on what patients and caregivers want and need to increase their confidence for a safe transition from hospital to home. This bundle includes:

- a patient-oriented discharge summary (PODS)
- patient and caregiver education using effective methods such as teach-back
- the involvement of caregivers (where possible) as part of the circle of care at key points throughout a hospital stay
- post-discharge follow-up

Accepted teams are eligible for up to $40,000 in seed funding, coaching, and numerous learning and networking opportunities to support the design, implementation and evaluation of this initiative.

The goals of the spread collaborative are to:

- Improve the patient and caregiver experience of transitions from hospital to home/community care
- Improve the confidence of patients (and caregivers) to manage their care as they transition to home
- Improve provider experience of care
- Reduce avoidable hospital readmissions
- Enhance the ability of teams to effectively partner with patients and caregivers in improvement initiatives

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

The deadline to apply is **August 15, 2018**.

[1] Throughout the prospectus, we use the terms "patient" and "caregiver" when referring to patients and caregivers who have lived experience interacting with the healthcare system. Caregivers are a family member or friend, identified by the patient (if they so choose), who provide unpaid assistance to their loved one living with a physical or mental health condition, who is chronically ill, frail, or is of advanced age (Caregivers of Nova Scotia, n.d.).

PREAMBLE: PARTNERING WITH PATIENTS IN QUALITY IMPROVEMENT

Since 2010, CFHI has supported 51 improvement teams across Canada to build their capacity to meaningfully engage patients and caregivers together with providers and leaders to improve the quality and experience of care. Through this work, we know that patients and families bring new and different ideas than when providers are working on their own.

"The ultimate aim of successful patient engagement is accelerating healthcare improvement and better health outcomes, with patients and staff having collective ownership of efforts to improve their shared healthcare service. Power resides not within any one stakeholder group but within the process of co-production/co-design".[2]

This new spread collaborative brings focus to the issue of care transitions through the eyes of patients and caregivers. Using the experience of patients and families through care transitions, accepted teams will implement a patient-oriented care transitions bundle to ensure that patients and caregivers have the knowledge and understanding they need for a safe transition from hospital to home. Patients and caregivers will be active partners throughout the process of this quality improvement initiative.

> " I think I lived the ideal situation where I was brought to the table not as a token patient, but as an equal partner. Clearly, if you are going to involve patients [in quality improvement initiatives], you truly need to involve them from the get go and allow them to contribute fully and let their voice be heard. If they are there so you can say you have a patient on the panel, then their interest will wane and their participation will not be full. I think I was fortunate that the project I was involved in allowed me to be totally involved. Definitely not the token patient – an equal partner right from the inception. "
>
> *Patient Advisor on CFHI-sponsored quality improvement team*

THE ISSUE

Throughout their lives, patients move through the health system with different healthcare teams in varied settings and, together with their caregivers, 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.[3] However, such care is not yet the norm in Canada, and silos that do not support patients and their caregivers 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.[4] Evidence demonstrates that transitions in care may result in adverse events and suboptimal patient outcomes, emergency room visits, or hospital readmissions.[5,6,7] 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.[8] While not all readmissions are avoidable, research suggests between 9% and 59% of readmissions may be prevented.[8]

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.[4] In particular, poor communication with patients and caregivers 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.[4,9,10] 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.[4,11] 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.[10] 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.

WHAT DO WE KNOW ABOUT THE 'IDEAL' CARE TRANSITION

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."[12,13]

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.[14,10] The specific transition from hospital to home has been well-studied. A recent systematic review conducted by Burke and colleagues[6] 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 caregivers 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.[6,15] 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

CFHI'S BRIDGE-TO-HOME SPREAD COLLABORATIVE

WHAT IS A CFHI COLLABORATIVE AND WHAT IS ITS PURPOSE?

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

THE GOALS OF THE BRIDGE-TO-HOME SPREAD COLLABORATIVE

This 17-month spread collaborative will support up to 12 interprofessional teams to implement key domains of the ideal care transition from hospital to home, including discharge planning, timely and relevant information, patient and caregiver education, and post-discharge follow-up. This collaborative will also enhance partnerships within interprofessional teams, including patients and caregivers, hospital, home and community providers and leaders who will work together to adapt, design, implement and evaluate a patient-oriented care transitions bundle that responds to patient and caregiver needs and deepens their involvement as part of the circle of care.

The goals of the spread collaborative are to:

- Improve the patient and caregiver experience of transitions from hospital to home/community care
- Improve the confidence of patients (and caregivers) to manage their care as they transition to home
- Improve provider experience of care
- Reduce avoidable hospital readmissions
- Enhance the ability of teams to effectively partner with patients and caregivers in improvement initiatives

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

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 caregivers as members of the improvement team will provide different insights and new ideas to improve care delivery.

The patient-oriented care transitions bundle includes the elements described below.

> " PODS is a simple, streamlined tool that helped my family organize and digest the information critical to the care of my mother post-discharge, and also sparked other information redesign ideas. I look forward to the continued spread of PODS, and translation to the many facets of our healthcare system! "
>
> *Valerie, Caregiver and PODS user.*

1. THE PATIENT ORIENTED DISCHARGE SUMMARY (PODS)

This tool engages patients, and caregivers in collaborative discharge planning to ensure they consistently receive information they need to effectively manage their health as they transition to home. PODS is an innovation that was co-designed with patients and caregivers, and is adaptable to many different settings. PODS provides a written, easy-to-understand, template with information that patients and caregivers 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 caregivers will adapt the PODS tool to reflect what is important to their specific patient populations to deliver patient-oriented discharge summaries.

PODS PATIENT ORIENTED DISCHARGE SUMMARY

OPENLAB Proud Member UHN

THE INNOVATORS: PODS AND OPENLAB

The University Health Network's (UHN) OpenLab (uhnopenlab.ca) co-designed the PODS tool together with patients and caregivers. Its intent is to provide patients and caregivers with the information they need to transition back home in a format that is understandable, relevant and actionable. OpenLab tested this tool with eight teams across Ontario, reflecting different sectors and patient populations including acute care, rehabilitation, paediatrics and mental health.

Early results demonstrate promising improvements in patient and provider experience: 92% of patients report understanding their discharge instructions, the purpose and use of their medication, and their follow-up appointments.[16] More than 90% of the 54 participating providers found PODS easy to use and valuable for patients. Over 80% of providers did not feel it added to their workload, but found it increased consistency and helped guide teaching.[16] Following this small pilot study, OpenLab secured ongoing funding through the Adopting Research to Improve Care (ARTIC) Program to expand the implementation of PODS to another 27 teams across all Local Health Integration Networks in Ontario which is currently ongoing. To date, over 30 teams across Ontario have pilot tested the use of this tool.

2. EFFECTIVE PATIENT AND CAREGIVER EDUCATION

Education to prepare patients and caregivers 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.[17] Using teach-back improves patient knowledge of their condition, patient adherence to the treatment plan and self-efficacy in managing their care.[9]

Improvement teams in the Bridge-to-Home spread collaborative will adopt effective education strategies such as teach-back method in the delivery of their PODS intervention to improve patient and caregiver understanding about their health condition and perceived self-efficacy in managing their condition when they return home.

3. WELCOMING CAREGIVERS AS PARTNERS IN CARE

For those patients fortunate to have caregivers 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[15]. Welcoming caregivers – as defined by the patient – as partners in care in hospital 24/7 provides opportunities for caregivers to be present throughout the care episode, and to be recognized as full participants in the circle of care. Caregiver participation in team rounds, patient and caregiver education, and discharge planning strengthens the ability of caregivers to take on the role of primary caregiver following discharge[4]. A recent review by Rodakowski and colleagues[18] found that discharge planning interventions involving caregivers were associated with positive results including decreased readmissions, shorter rehospitalizations and lower costs of post-discharge care.

Teams in the Bridge-to-Home Spread Collaborative will identify opportunities to welcome caregivers 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 caregivers often experience challenges in knowing where and how to access care after discharge, and to carry out instructions provided at discharge.[4,19] While post-discharge follow-up methods continue to be tested and have demonstrated mixed results,[20] there is evidence to support how post-discharge telephone calls and home visits have identified safety issues in the home.[7] 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.[21,22,23]

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 caregivers following discharge (e.g. home visits, follow-up calls after discharge) based on patient needs and risk.

QUALITY IMPROVEMENT AND EVALUATION

As part of CFHI's commitment to enhancing capacity, improvement teams will 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 caregivers in redesign efforts led to changes in processes and systems of care. CFHI will work together with teams to develop a core set of measures for all teams in the collaborative. In addition, teams will be supported to develop other indicators relevant to their specific initiatives and contexts.

Proposed measures include:

- Process measures to understand the experience of patients and staff collaborating on a quality improvement project
- Patient and caregiver experience
- Confidence of patients and caregivers to manage their care as they transition home
- Provider experience
- Hospital readmissions

BENEFITS OF JOINING THE BRIDGE-TO-HOME SPREAD COLLABORATIVE

Healthcare jurisdictions and accrediting bodies have increasingly focused on the patient experience of care. The Bridge-to-Home Spread Collaborative seeks to improve the patient and caregiver experience as they transition from hospital to home by implementing a patient-oriented bundle that has been co-designed with patients and caregivers to meet their needs.

This collaborative will provide a common framework to strengthen connections between institutional care, patients and caregivers, and community/primary care/home care. Interventions will be tailored by each improvement team based on the context and needs of their patients and caregivers, and in alignment with organizational priorities. Working together with CFHI using an all-teach-all-learn approach, improvement teams will enhance their capacity to partner with patients and caregivers 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 caregivers. 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 caregivers 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 workshop(s) to foster cross-team learning
- A network of expert faculty and coaches
- Team coaching to ensure the development of meaningful engagement and provide expertise related to the patient-oriented care transition bundle, as well as support for the rapid pace of testing change and troubleshooting
- Learning tools and activities through an online learning platform

CFHI: WORKING SHOULDER-TO-SHOULDER WITH YOU

CFHI identifies proven innovations and accelerates their spread in healthcare organizations and jurisdictions across Canada. We support interprofessional teams of healthcare providers, non-healthcare staff, patients and caregivers, to adapt, implement and evaluate improvements in the patient experience of care, provider experience, population health and value-for-money. We work shoulder-to-shoulder with you to improve health and care for all Canadians. In our collaboratives, learning activities provide a balance of theory, tools and practical techniques to build capacity in the following core competencies for improvement teams:

- **Working collaboratively towards improvement with patients and caregivers, as part of interprofessional teams:** Teams will gain proficiency in developing partnerships with patients and as part of their improvement teams to design and implement patient-oriented practices and data-driven improvements.
- **Identifying and interpreting evidence for improvement:** Teams will gain proficiency through setting goals and targets – including implementation and spread goals – and designing patient-oriented approaches to care transitions.
- **Designing and implementing improvement:** Teams will understand and apply quality improvement methodology for developing and sustaining evidence-informed patient oriented improvements.
- **Leading change in complex organizations/environments:** Teams will understand and develop proficiency in applying principles of change management across the organization.
- **Evaluating, monitoring and reporting improvement:** Teams will gain proficiency in using data to set targets, monitor progress and inform care planning, and they will also develop open channels of communication to share information about progress and key results.
- **Planning for spread and sustaining the gains:** Teams will gain proficiency in assessing the sustainability and spread of their improvement efforts.

> "... pockets of extraordinary creativity and innovation dot the Canadian healthcare landscape. Local, regional and even provincial programs worthy of emulation have simply not been scaled up across the nation... CFHI punches above its weight in scaling up innovation..."
>
> *Federal Advisory Panel on Healthcare Innovation (2015)*

KEY DATES

Please note, all dates are to be confirmed.

Call for Applications	Call for applications launched	May 30, 2018
	Informational webinar *	June 19, 2018
	Call for applications closes	August 15, 2018
	Teams notified of acceptance into collaborative and sharing of MOUs	Week of September 10, 2018

Planning and Start-up	Orientation webinar 1	October 3, 2018
	MOU signed and returned to CFHI	October 22, 2018
	Face-to-Face Workshop (Ottawa)	November 2018

Adapting, Testing and Refining the Innovation	Content webinars that will focus on topics relevant to	December 12, 2018
	the patient-oriented care transitions bundle,	January 23, 2019
	patient engagement practices,	March 6, 2019
	quality improvement,	April 17, 2019
	implementation,	May 22, 2019
	evaluation, and	July 10, 2019
	sustainability, and	August 21, 2019
	change management	September 25, 2019
		October 30, 2019
		December 11, 2019
		January 15, 2020

Post-Collaborative Team Follow-up	Survey/Interview	Approximately 3-6 months post-collaborative

* All webinar times are noon to 1:00 p.m. EST.

HOW TO APPLY

THE CALL FOR APPLICATIONS IS OPEN FROM MAY 30-AUGUST 15, 2018

Pre-application teleconference calls or queries can be initiated by contacting Christine.Maika@cfhi-fcass.ca.

JOIN THE INFORMATIONAL WEBINAR

To learn more about the Bridge-to-Home Spread Collaborative, please join CFHI faculty and staff on an informational webinar on June 19, 2018. Register online at: https://www.research.net/r/BridgeToHome

ASSEMBLE YOUR IMPROVEMENT TEAM

Patients and caregivers as partners are integral members of the improvement teams. Two types of improvement teams – a network team or a single institution – will be considered for this collaborative. Where possible, we strongly encourage the assembly of a network team (consisting of two or more organizations) to strengthen collaboration between care settings.

Improvement teams accepted into the collaborative will be comprised (at a minimum) of the following team members/roles (for both network and single institution teams):

- A **Team Lead** who has the time, resources and accountability to:
  - Coordinate and oversee the day-to-day activities of development and execution of the project implementation and spread plan
  - Be the key coordinator and motivator
  - Coordinate team attendance at regular educational webinars
  - Plan for and provide overall guidance and oversight of the initiative to ensure milestones are met
  - Serve as a main point of contact for CFHI
  - Be primarily accountable for the design, implementation, and evaluation of the initiative
  - Be responsible for all internal network communications (e.g. internal updates)
  - Ensure regular and ongoing communication with staff, patients, caregivers and relevant committees/councils
  - Lead and coordinate necessary activities with staff, leadership, patients and caregivers
- A **Patient and/or Caregiver Advisor** who will offer the perspective of the patient and caregiver experience throughout the collaborative. Patient and caregiver advisors will be integral members of the improvement team – attending meetings, identifying needs and solutions, testing ideas, and evaluating outcomes. As well, this role may serve as a liaison between the initiative and other patients and caregivers/councils within the organization, and support broader engagement practices throughout the initiative.
- An **Evaluation Lead** who will support the tracking of results over time. Common definitions and indicators will be used across teams, informed by Evaluation Leads, who will also supply anonymized data at baseline, throughout and post-collaborative to allow for progress reporting and sharing across sites as required.

- An **Executive Sponsor** who will provide senior level support and champion this initiative throughout the organization. The Executive Sponsor will ensure the alignment of this initiative with strategic priorities of the organization, ensure protected release time for staff, and secure resources to enable the implementation and sustainability of this initiative. Network teams will require executive sponsorship from each organization involved.

It is strongly recommended that teams consider additional team members with expertise in the following roles:

- Additional patient and caregiver advisors (two or more)
- Staff and leaders from acute care, primary care, home care and/or community care
- Broader community organizations (e.g. community pharmacy, seniors' organizations)
- Front-line staff responsible for implementing the change: this may include allied health professionals, managers, nurses, nurse educator, or others
- A quality improvement advisor

NB: Network teams should include representatives from all organizations involved.

COMPLETE THE EXPRESSION OF COMMITMENT

Applicants must complete an Expression of Commitment by August 15, 2018.

NOTIFICATION OF SUCCESSFUL APPLICATION

An expert merit review panel will review the applications, confirm the selection of teams to participate in the collaborative based on submitted applications and provide feedback as needed.

Improvement teams will be notified of the status of their application the week of September 10, 2018.

SIGN THE MEMORANDUM OF UNDERSTANDING

Teams will be asked to sign a memorandum of understanding (MOU) with CFHI that reflects CFHI's support and the commitment of the organization and team members. The deadline to submit the signed MOU is October 22, 2018.

If you would like to arrange a call with CFHI to discuss your application, contact Christine.Maika@cfhi-fcass.ca.

ETHICS

It is the responsibility of each organization applying to participate in the Bridge-to-Home Spread Collaborative to determine if ethics approval from a research ethics board is required. Organizations should identify if the nature of the improvement project will require ethics board approval at the application stage. If applicable, plans to attain ethics approval must be described and factored into the timeline of the proposed improvement project. Tri-Council Policy Statement (TCPS2) governs requirements pertaining to research ethics in Canada, distinguishes quality improvement and research, and advises when seeking ethics approval is required.

Article 2.5: "Quality assurance and quality improvement studies, program evaluation activities, and performance reviews, or testing within normal educational requirements when used exclusively for assessment, management or improvement purposes, do not constitute research for the purposes of this Policy, and do not fall within the scope of [research ethics board] review." For more information, please consult the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2014), the Tri-Agency Framework: Responsible Conduct of Research (2016), TCPS: Section 6: Research Involving Aboriginal Peoples and First Nations Principles of OCAP™ (ownership, control, access, and possession).

CONFLICTS OF INTEREST

By completing the Expression of Commitment, the Lead Organization and Network Team members confirm that they have reviewed and understood CFHI's Conflict of Interest Policy, including the rules regarding the eligibility of CFHI employees, directors, registrants and agents. Organizations from which any members of CFHI's Board of Directors, or Foundation agents or employees, receive remuneration are eligible to apply to this competition. Applicants must fully disclose any relationship with current members of CFHI's Board of Directors.

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