SAFE-CT Project:

Safe and effective person-and-family-centered care practices during transitions between hospital-based care and home care - A mixed methods study

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We know…

- Care transitions lead to fragmentation in care, decreased quality of care, and an increase in adverse events (McMurray et al., 2013, Forster et al. 2003, Kripalani et al. 2007, Laugaland et al., 2012)
- Older adults (>65 years) with multiple chronic conditions comprise of 5% of the population which accounts for approx. 66% of the health care costs (OMHLTC, 2012)
- Engaging patients and families can improve their quality of care (Carmen et al. 2013, Entwistle et al. 1998)

Purpose

To identify best practices and to engage key stakeholders in the development of a preliminary list of indicators to monitor safe PFCC transitions from hospital to home.

Specific Objectives

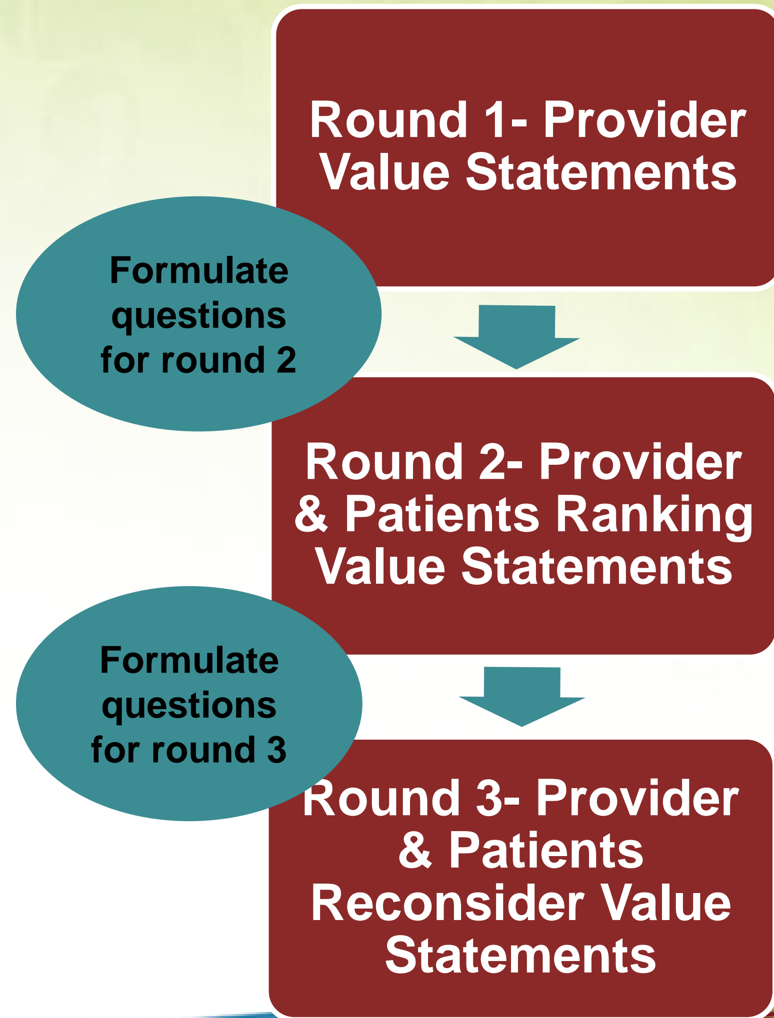
- Describe evidence-based practices for safe person- and family-centered care transitions
- Describe patients and families' perceptions of key factors to improve safety and facilitate person- and family-centered care during transitions from hospital to home
- Identify potential indicators that best reflect safe person- and family-centered care transitions

Methods

- Phase 1: A critical analysis of the literature
- Phase 2: A descriptive qualitative study
- Phase 3: A Delphi survey with both providers and patients/families

The Delphi Technique

Results of patient and family interviews and systematic review



Round 1 Questions

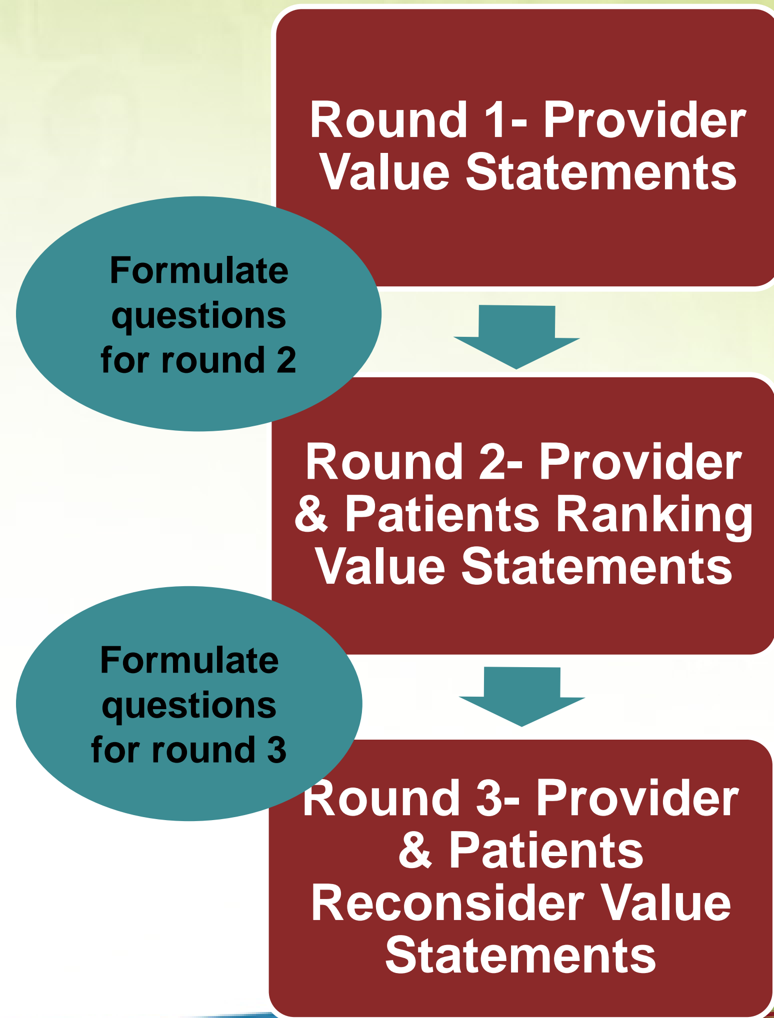
1) What are the CURRENT PRACTICES you use to ensure overall quality and safety during care transitions between hospital and home?

2) For each of the current practices identified, who is your TARGET PATIENT POPULATION?

3) For each of the current care transition practices, what MEASURES do you use to monitor the practice?

4) If you do not monitor the practice, how would you IDEALLY monitor it (if you could)?

The Delphi Technique



Results of patient and family interviews and systematic review

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Findings- Comparison between provider and patients/families - Agreements

	Provider statements		Patient / Family Statement	
Access to appropriate help (i.e. supports or care providers/ caregivers at home or community facility)	Patients have the help they need after going home	100%	You have the help you need after going home	100%
Self-care or self-management plan: Provide information and confirm level of understanding	Patients report that they have a good understanding of the things they can do to manage their health when they left the hospital	100%	You have a good understanding of the things you can do to manage your health when you left the hospital	100%
Connection to home care services	Patients are contacted about the home care services that they will receive after going home (if required)	100%	You are contacted about the home care services that you will receive after going home (if required)	96%
Standardized clinical assessment by home care provider	Patients' home care nurses assessed their health needs (if applicable)	93%	Your home care nurse assessed your health needs (if applicable)	100%

Findings- Comparison between provider and patients/families – Different Priorities

	Provider statements		Patient / Family Statement	
Communication of medication list to pharmacist	Patients' pharmacist receives a list of all their medications at discharge from hospital	93%	Your pharmacist received a list of all your medications at discharge from hospital	88%
Understand medications	Patients have a clear understanding about all of their prescribed medications before leaving the hospital	86%	our have a clear understanding about all of your prescribed medications before leaving the hospital	100%
Communication between hospital clinicians' and receiving clinicians upon discharge	Patients' family doctor and care providers or clinicians in the community receive the contact information of their hospital doctor	86%	Your family doctor, and other care providers or clinicians in the community receive the contact information of your hospital doctor	92%

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The Next Steps

- Operationalize the statements
- Align work with CIHI ongoing development of key indicators
- Development of standards for care transitions

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