



## **Local project points to ways of easing patient transitions from hospital to home**

**Trenton, ON, July 7, 2008** – Patients and their caregivers in the South East want and need timelier, clearer information with proactive community placement planning to find the best, next care when moving from hospital to home. These are some of the key findings from phase 1 of a quality improvement project called *Having their Say & Choosing their Way: helping patients and caregivers move from hospital to home* be it -- a personal residence, retirement home, long-term care home or supportive housing.

The project is funded by the health policy think tank The Change Foundation, in partnership with the Ontario Association of Community Care Access Centres (OACCAC). It began last February when the South East Community Care Access Centre (SE CCAC) and Quinte Health Care (QHC) Trenton Memorial signed on to be the first participants in the three-year project which will involve two other Ontario sites.

The SE CCAC and QHC Trenton Memorial worked with consultants to map all the big and small steps and decisions that patients and their caregivers must take -- and all the interactions and arrangements with different service providers -- as they prepare to leave hospital for home.

OACCAC CEO Margaret Mottershead and Change Foundation CEO Cathy Fooks commended the South East team for its dedication and contribution to advancing the understanding of how to improve the often trying patient journey from hospital to home for local residents and beyond.

The local project group found that the move from hospital to long-term care home involved 160 total steps including 69 handling steps, 36 forms, four (often long-distance) family trips to the hospital, and 15 delays. The process for making a bed offer was also quite complicated: a total of 53 steps involving five separate staff members entering client information into nine different forms and five other patient tracking tools.

Following interviews with 15 recently discharged elderly patients and/or their caregivers (all of whom had spent time in hospital when they should have received care elsewhere), the group summed up their needs and perspectives with the following statement: “I want accurate information that I can understand at the right time and place, including viable options, so my family and I can make the right decision for us. I want to feel confident that people care and to be treated with respect.”

Once the mapping and interviews were done, all the players – including the patients and caregivers –discussed what steps and interactions were valuable – and which ones were not -- to people facing a health crisis and leaving the hospital for another care setting.

The findings from the project highlight what impedes patient discharge and include a collection of compelling stories to illustrate patient and caregiver experiences. For example, some elderly patients end up in the emergency department because their caregivers are “burnt out” and unsure of where to turn; other patients said they felt anxious and fearful about the long-term care placement process and expressed concerns about transparency. Patients often praised care providers and their efforts, and supported the project’s efforts to focus on improving the process, not laying blame.

“The findings of this project will help the CCAC and our partners as we work together to better serve our population,” said David Marshall, Executive Director of the SE CCAC. “We will be better positioned to serve our clients in the way they want to receive service,” he continued.

Local project leaders already have plans to implement some specific changes to streamline and improve the process for patients and their families.

“QHC is working on a number of creative projects to help reduce the high number of alternate level of care patients who would be better served in another setting in the community,” said Katherine Stansfield, Vice President, Patient Services & Chief Nursing Executive. “We need to continue to work with our health care partners to ease the transition from hospital to home, particularly since South Eastern Ontario has one of the highest percentages of people over 75 years of age.”

“This project is an excellent start in better understanding how to improve this critical health care transition for Ontarians. We know that some of the communication and co-ordination problems raised here are not necessarily unique, and we will continue to learn more and compare at two other regional sites. This work will point to systemic ways to improve patient experience, decrease unnecessary hospital stays, reduce community-based adverse events and eliminate confusion about health care roles and responsibilities,” said Fooks. Overall recommendations for changes to process, policy or practice will follow after analyses of findings from all phases of the project and further market research in early 2011.

“This has been a great opportunity to obtain client and caregiver feedback about the transition from hospital to home – wherever home may be. The CCACs, as navigators of the healthcare system, partner with clients and families to help them make the best decisions and then to implement those in a seamless manner. This study provides insights that our members will find valuable as they work to continually improve services,” said Margaret Mottershead, OACCAC CEO.

The Toronto CCAC and an area hospital will be involved in the second phase of the project; details will be announced in the fall. For more information on the project, please visit [www.changefoundation.com](http://www.changefoundation.com)

*The Change Foundation is a policy think tank that generates research, analysis and informed discussion on key and emerging health system issues, starting with the integration of health-care services in communities across Ontario.*

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

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**For more information, please call:**

**The Change Foundation  
Anila Sunnak  
(416) 205-1325**

**South East CCAC  
Joel Cote  
(613) 544 8200, ext. 4258**

**Quinte Health Care  
Susan Rowe  
(613) 969-7400, ext. 2331**