Introduction to the Home to Hospital to Home (H2H2H) Transitions Change Package

2022

Updated Nov 2022

ALBERTA MEDICAL ASSOCIATION | ACTT Accelerating Change Transformation Team

actt.albertadoctors.org

Contents

Acronyms

AHS: Alberta Health Services

AMA: Alberta Medical Association

ACTT: Accelerating Change Transformation Team

EMR: Electronic Medical Record

H2H2H: Home to Hospital to Home

HQCA: Health Quality Council of Alberta

PCNs: Primary Care Networks

PBP: Potentially Better Practice

PHCIN: Primary Health Care Integration Network

QI: Quality Improvement

Change Package Development

The Home to Hospital to Home (H2H2H) Transitions Change Package was developed by the Alberta Medical Association (AMA) Accelerating Change Transformation Team (ACTT). Input on the change package was sought from Practice Facilitators (PFs) at several Primary Care Networks (PCNs) across Alberta. The H2H2H Transitions Change Package supports the H2H2H Transition Guideline, which identifies leading operational practices in facilitating effective transitions of care from home to hospital and back home. The H2H2H Guideline is a critical resource to enable system integration. Partners in this initiative include the Primary Health Care Integration Network (PHCIN), primary care and community health service providers, specialists, patients, and families.

The H2H2H Transitions Change Package was developed, tested, and disseminated to stakeholders between April 2020 and October 2022.

How to Use the Change Package

This change package is intended to be used by practice facilitators, physician champions, and clinical improvement teams to support process improvements for patients transitioning from home to hospital and back to home. While the change package does not include all process improvements for transitions of care, it provides clinical teams with a place to start.

Change does not always lead to improvement; however, all improvement requires change. The H2H2H Transitions Change Package outlines several change ideas that have been derived from a review of the literature, clinical practice guidelines, and expert recommendations. If implemented, the changes are anticipated to improve the care of patients experiencing a transition of care. The goal is for care teams to use the change ideas in the change package to drive improvement in their own practice, PCN, health neighbourhood, and zone. Many change ideas, which serve as a menu of options, are included in this change package. Teams should not try to implement all the change ideas simultaneously. Also, it is unlikely that all the change ideas will be suitable for each practice setting.

The H2H2H Transitions Change Package is organized around the Sequence to Achieve Change (Figure 1.) The Sequence to Achieve Change is a stepwise change management approach that incorporates the Institute for Healthcare Improvement Model for Improvement. This document follows the steps in the sequence to help teams select and test changes that can be applied in the care team's context.

Change does not always lead to an improvement. However, all improvement requires change.

Figure 1. The Sequence to Achieve Change

SEQUENCE TO ACHIEVE CHANGE

1. FORM AN IMPROVEMENT TEAM

- ☐ Assemble a team that represents all areas and roles of the clinic; consider including patients on your team.

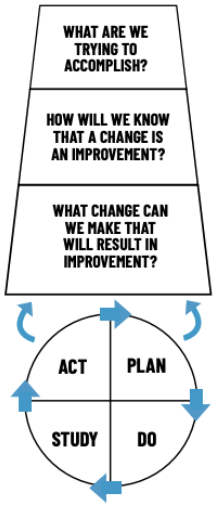
2. CLARIFY THE PROBLEM/OPPORTUNITY

- ☐ Articulate the problem you want to solve. Use evidence & data to strengthen your rationale (e.g., HQCA Physician Panel Report).
- ☐ For improvement projects with higher complexity, create a project charter.

3. MAP PROCESSES

- ☐ Visually depict the sequence/steps of events in a process; identify gaps.
- ☐ Document the new, interim, and final processes.

4. USE MODEL FOR IMPROVEMENT



SET AN AIM STATEMENT

- ☐ The aim should be time specific and measurable; it should also define the specific population of patients or other system that will be affected.

IDENTIFY MEASURES

- ☐ Determine the baseline – the measure of how you are currently doing.
- ☐ Use process, outcome, and balancing measures to check if you are improving.

SELECT CHANGES OR POTENTIALLY BETTER PRACTICES (PBPs) TO TEST

- ☐ Ideas for change may come from people who actually perform the work, or from the experience of others who have successfully improved (e.g., evidence).

TEST CHANGES (PDSA)

- ☐ The Plan-Do-Study-Act (PDSA) cycle is short hand for testing the potentially better practices in the real work setting — by planning it, trying it, studying the results together, and acting on what is learned.

5. SUSTAIN THE GAINS

- ☐ Complete periodic measures; display your results.

6. SPREAD THE SUCCESSFUL CHANGES

- ☐ After successful implementation of a change, or package of changes for a pilot population, the improvement team can spread the changes to other parts of the clinic or to other clinics.

7. CELEBRATE!

- ☐ Plan to celebrate at milestones along the improvement journey, as well as when you achieve your aim. Recognize and highlight the efforts and accomplishments of the team.

SOURCES:

| www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx | Vermont Oxford Network-Sequence to Achieve Change | TOP QI Guide |
| Model for Improvement: Associates in Process Improvement, www.apiweb.org/index.php |

1 Form an Improvement Team

Quality improvement focuses on improving processes that affect many different team members. The first step towards improvement is to assemble a quality improvement team in your clinic (if one has not been established yet). To engage the care team, consider using engagement tools such as an elevator speech (see Sequence to Achieve Change Workbook, activity 1 [Appendix A]), linking the features and benefits of working on H2H2H transitions of care. Focus on the value proposition for the physician, clinic, and patient. You can refer to the H2H2H Potentially Better Practices: Rationale and Evidence document [Appendix B].

Ideally, the quality improvement team should include representation from all areas and roles in the clinic (e.g., physician, allied health professionals, reception, etc.). Teams may wish to also consider including a patient with lived experience on the team. If so, you can reference the Including a Patient Partner on an Improvement Team guide [Appendix C]. It is recommended that teams include someone with quality improvement and facilitation skills (e.g., a PCN Practice Facilitator) to support the team with getting started and measuring progress. Additionally, it is recommended that you include a leader with decision-making authority (e.g., the clinic owner, physician lead, or office manager) on your team to guide, support, and encourage the team, as well as ensure the sustainability and longevity of any changes.

2 Clarify the Problem or Opportunity

It is critical to define the problem or opportunity related to the H2H2H transition of care process that your team will begin working on. Have the quality improvement team discuss their current processes for supporting patients with a H2H2H transition of care. Consider the following questions:

- What is the problem?
- Who does the problem affect?
- When is it a problem?
- Why should we care?
- How does it affect patients?

It may be helpful to use quality improvement tools here, such as a Cause-Effect Diagram, 5 Why's, or a Run Chart. These tools are posted on the ACTT website.

When brainstorming, be sure to focus on the problem and not the solution. After your discussion, articulate the problem or opportunity in a sentence or two. Use evidence and data to strengthen your rationale (e.g., from a Health Quality Council of Alberta [HQCA] Panel Report or EMR report). For improvement projects with higher complexity, consider creating a project charter.

An example of a problem statement is:

"The team at X clinic is frustrated because they are not notified in a timely manner when patients are admitted or discharged from hospital. This prevents the team from planning proactive care in the medical home."

3

Map the Process

Visually identifying the sequence or steps within a specific process will help care teams to identify redundancies and gaps. Start by naming the process under investigation so that all team members are focusing on the same thing. Next, determine the start and end points in the process. Use your team to brainstorm all the steps that happen in between. Finally, arrange your steps in order. You may wish to distinguish steps by clinical role. Use this Process Mapping Guide as an aid. Leverage process mapping skills from your practice facilitator, if possible.

Once you have your current state mapped, review it as a team. Consider the following questions:

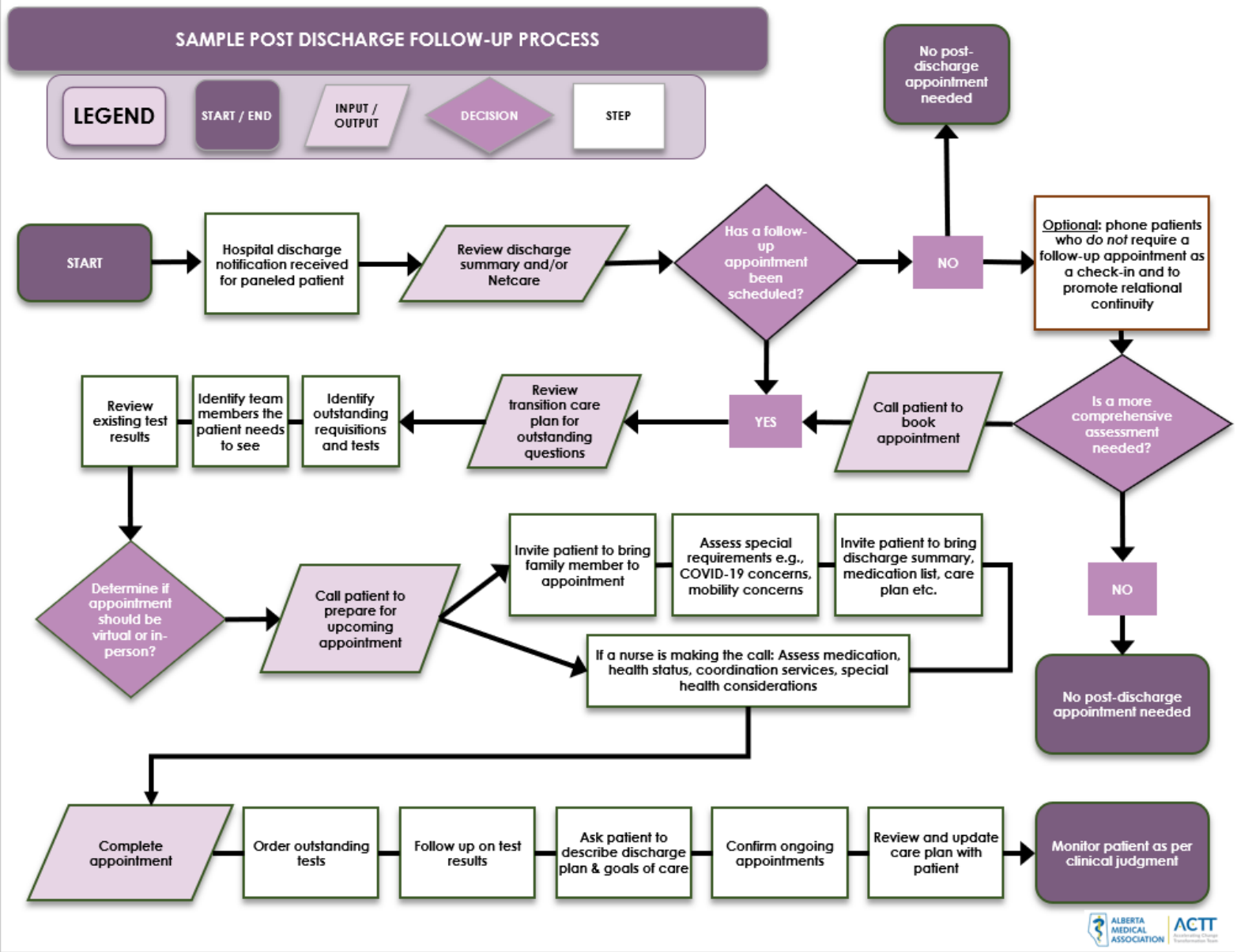
- Where do we see waste/inefficiencies in the process?
- What are the slowest parts of the process?
- When do pain points occur?
- Can the process be done differently or in a different order?
- Are the right people doing the right tasks with the right resources?
- What or who drives the process?

Examples of processes your team may wish to map for this change package include:

- Process for reviewing hospital discharge summaries
- Process for scheduling follow up appointments in the medical home
- Process for checking risk of readmission score
- Process for contacting specialist advice programs, homecare, and others

See sample process map below (Figure 2).

Figure 2. Sample Process Map



4 Use the Model for Improvement

When making a change, the Institute for Healthcare Improvement 'Model for Improvement' asks three questions:

AIM	MEASURE	CHANGE
What are we trying to accomplish?	How will we know that a change is an improvement?	What change can be made that will result in an improvement?

These three questions are followed by small tests of change called Plan-Do-Study-Act (PDSA) cycles.

Aim Statement

When developing an aim statement, first consider your current circumstances. Then consider what aspects you would like to improve. An aim statement should define a specific population of patients or part of the system that will be affected. The statement should answer the questions:

1. What are we trying to improve?
2. By how much?
3. By when?

An example aim statement for the H2H2H Transitions Change Package is:

"By x date x clinic will offer a follow-up appointment, as appropriate, to x patients within 7 days post-hospital discharge"

Teams may also need to develop aim statements specific to each of the potentially better practices (PBPs) that are selected to be tested (PBPs defined and detailed below).

Identify Measures

Measurement is a key component of quality improvement. Measurement allows you to track the changes that are occurring and assess their impact. **Process, outcome** and **balancing** measures should be collected to ensure that the change you are making is an improvement. However, remember to collect just enough data to inform decisions.

A **process measure** measures whether an activity has been accomplished. Often used to determine if a PDSA cycle was carried out as planned (e.g., # of follow-up appointments when patient brought a family member).

An **outcome measure** measures the performance of the system under study. It often relates directly to the aim of the project and offers evidence that changes are having an impact (e.g., # of high-risk patients with visits to the medical home within 14 days post hospital discharge).

A **balancing measure** determines the impact of a change on a separate part of the system (e.g., time to third next available (TNA) appointment).

Sample process, outcome, and balancing measures for this change package are included in Table 1 below. The sample process measures are listed as counts (e.g., # of patients with high-risk of readmission score who are offered a scheduled follow-up appointment within 7-14 days) or percentages. If you wish to present your measures as rates, simply use the suggested process measure as the numerator and determine your denominator.

For example,

$$\frac{\#\ of\ high\ risk\ pts\ offered\ a\ follow-up\ appointment\ within\ 7-14\ days\ [e.g.,\ \boldsymbol{n=6}]}{\#\ of\ high\ risk\ pts\ discharged\ from\ hospital\ this\ month\ [e.g.,\ \boldsymbol{n=8}]}\ x\ 100$$
$$= 75\%$$

After you have selected your measure(s), start by determining your baseline to understand your current state. Determine an appropriate measurement interval (e.g., daily, weekly, monthly) and plot results on a run chart. Leverage measurement skills from your practice facilitator, if possible.

Select Changes or Potentially Better Practices (PBPs) to Test

Potentially Better Practices (PBPs) are change ideas that you might try out and test to understand if they make an improvement in your context. PBPs may come from peer-reviewed literature, the experience of others who have made successful improvements, or they may come from those who perform the work. It is important to select the PBPs that are endorsed by the clinical team members.

Table 1 below sets out possible changes a team can make to improve processes for patients transitioning care from H2H2H. The table has the following headers:

High Impact Changes: These represent the main areas of focus that are considered most critical for a care team to work on to achieve optimal performance in a particular area, such as transitions of care.

Potentially Better Practice (PBP): These are the specific processes and practices that can be tested and implemented based on clinic context. They are typically derived from related literature, clinical practice guidelines, and expert recommendations.

Process Measures: Defined above, these measures are typically simple to implement and track.

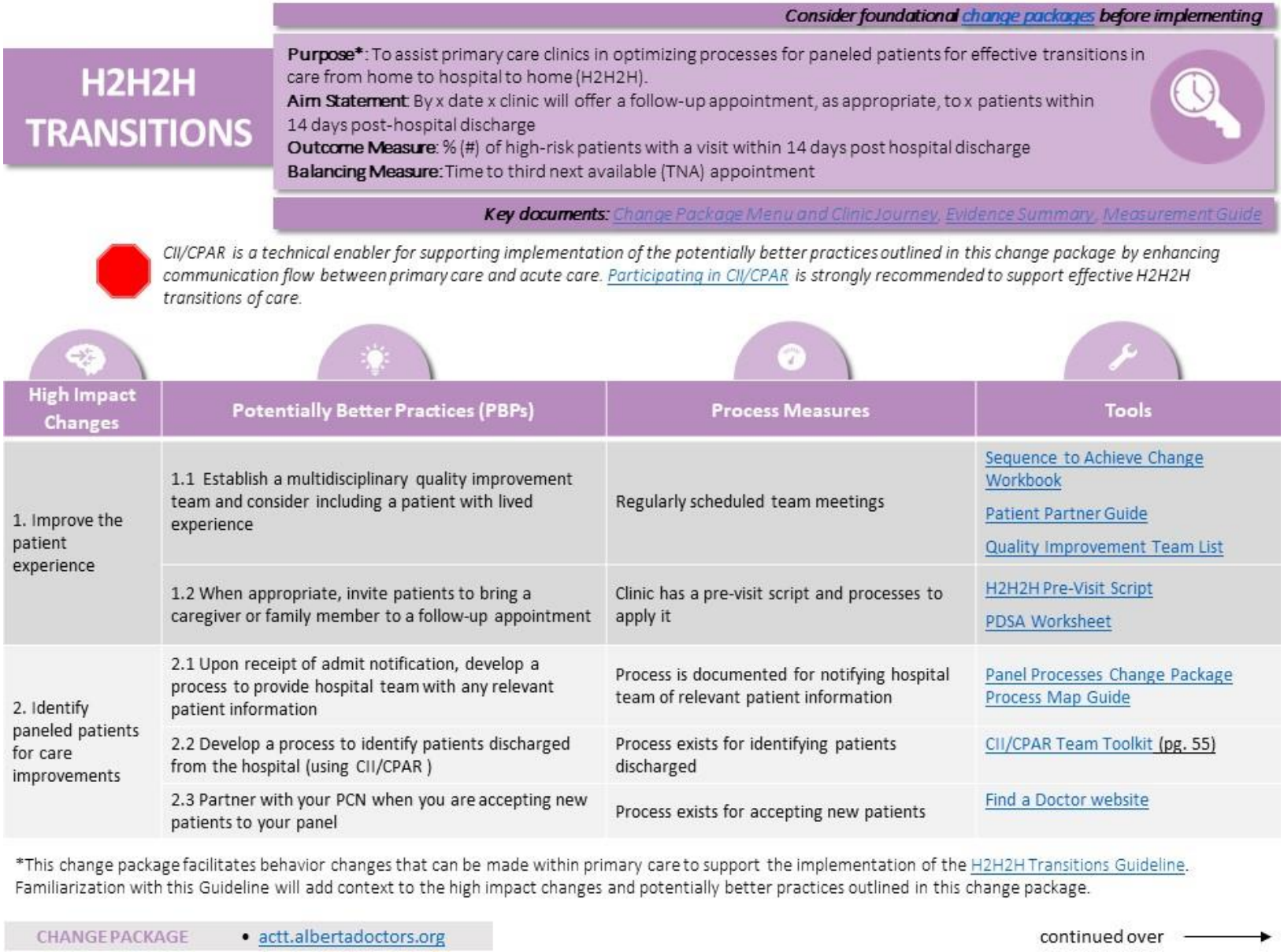
Tools: These are resources that may support teams in implementing the PBP.

To see the rationale for why each PBP was selected as a change idea, and some ideas for implementing it in your own clinic, refer to the H2H2H Potentially Better Practice: Rationale and Evidence document.

Test Changes (PDSAs)

After a change idea is selected, use Plan-Do-Study-Act (PDSA) cycles to test changes in a real-world setting. Consider starting with just one patient and one provider. Use this PDSA Worksheet as a guide.

Figure 1. H2H2H Transitions Change Package Summary



H2H2H TRANSITIONS

Consider foundational change packages before implementing

Purpose*: To assist primary care clinics in optimizing processes for paneled patients for effective transitions in care from home to hospital to home (H2H2H).
Aim Statement: By x date x clinic will offer a follow-up appointment, as appropriate, to x patients within 14 days post-hospital discharge
Outcome Measure: % (#) of high-risk patients with a visit within 14 days post hospital discharge
Balancing Measure: Time to third next available (TNA) appointment

Key documents: Change Package Menu and Clinic Journey, Evidence Summary, Measurement Guide

CII/CPAR is a technical enabler for supporting implementation of the potentially better practices outlined in this change package by enhancing communication flow between primary care and acute care. Participating in CII/CPAR is strongly recommended to support effective H2H2H transitions of care.

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	Tools
1. Improve the patient experience	1.1 Establish a multidisciplinary quality improvement team and consider including a patient with lived experience	Regularly scheduled team meetings	Sequence to Achieve Change Workbook Patient Partner Guide Quality Improvement Team List
	1.2 When appropriate, invite patients to bring a caregiver or family member to a follow-up appointment	Clinic has a pre-visit script and processes to apply it	H2H2H Pre-Visit Script PDSA Worksheet
2. Identify paneled patients for care improvements	2.1 Upon receipt of admit notification, develop a process to provide hospital team with any relevant patient information	Process is documented for notifying hospital team of relevant patient information	Panel Processes Change Package Process Map Guide
	2.2 Develop a process to identify patients discharged from the hospital (using CII/CPAR)	Process exists for identifying patients discharged	CII/CPAR Team Toolkit (pg. 55)
	2.3 Partner with your PCN when you are accepting new patients to your panel	Process exists for accepting new patients	Find a Doctor website

*This change package facilitates behavior changes that can be made within primary care to support the implementation of the H2H2H Transitions Guideline. Familiarization with this Guideline will add context to the high impact changes and potentially better practices outlined in this change package.

CHANGE PACKAGE • actt.albertadoctors.org

continued over

ALBERTA MEDICAL ASSOCIATION | ACTT Accelerating Change Transformation Team

H2H2H TRANSITIONS CHANGE PACKAGE

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	Tools
3. Optimize care processes	3.1 Develop a process to review patient discharge summary* from hospital *The H2H2H Transitions Guideline uses 'transition care plan' to describe the discharge summary'	Process is documented for reviewing discharge summary	H2H2H Roles & Responsibilities Guide Process Map Guide
	3.2 Develop a process to check each discharge summary for a risk of readmission score* (documented in 4.1)	Process is documented for checking risk of readmission score	LACE Index Scoring Worksheet *LACE is the preferred risk of readmission score at Alberta Health Services
	3.3 If a risk of readmission score has not been provided by acute care, develop a process to determine who your high-risk patients are	A process is documented for determining high-risk patients	PDSA Worksheet
	3.4 Develop a process to offer and manage follow-up care, as appropriate	A process is documented for offering and managing follow up care.	Post Discharge Follow-up Process Map (Sample) Virtual care tools
	3.5 Create a plan for the patient appointment (e.g., medication reconciliation, review care plan, results and outstanding test follow up)	A plan is documented	My Next Steps: Getting Ready to Leave the Hospital
4. Standardize documentation	4.1 Standardize entry of admit notifications, discharge notifications and discharge summaries 4.2 Standardize entry of patient risk for hospital readmission in the patient record (Aligns to 3.2)	#/% of discharged patients with risk assessment documented in the patient record	EMR Guides
5. Coordinate care in the medical home	5.1 Establish clear roles and responsibilities for supporting patients in transitions	Documented roles and responsibilities of team members	H2H2H Roles & Responsibilities Guide Sample Huddle Checklist
6. Coordinate care in the health neighborhood	6.1 Communicate as needed post-transition with care providers outside of the medical home (e.g., primary care accessing specialist advice and liaising with homecare or other members of the extended healthcare team)	Process in place for contacting specialist advice programs, homecare, and other	Warm Hand Offs Specialist Advice Programs: Specialistlink, ConnectMD, RAAPID (coming soon)

CHANGE PACKAGE • actt.albertadoctors.org

5

Sustain the Gains

You have gathered a team, set an aim, and have tested and measured changes. Now you have to maintain the gains the care team has made. Some strategies to consider for maintaining improvements are[1]:

- **Standardization:** helps to ensure that new processes are followed. Standardizing tasks by role may help to create clarity around who is responsible.
- **Accountability:** does not rely on hierarchical structures, rather it promotes camaraderie amongst the team.
- **A visual management system** (e.g., QI board): develop and continually update a compelling visual scoreboard to keep team members engaged and energized.
- **Daily communication:** beyond the quality improvement team. Ensure everyone on the team is aware of the change and understands why it is being made.
- **A problem-solving technique:** when problems inevitably arise, use a PDSA cycle approach to solve them.

Additionally, measurement does not stop once you have improved your outcomes. Continue to periodically measure your results to ensure that improvements are sustained over time. To save time and increase accuracy, standardize measurement in the EMR (i.e., save your search), so the same measure is run the same way at each time interval.

Measurement does not stop once you have improved your outcomes.

6

Spread Successful Changes

After successful implementation with the initial provider(s), the improvement team can work to spread learning and changes to other providers/areas of the clinic or to other clinics within the PCN or zone. Although actual spread occurs at the end of a successful improvement initiative, improvement teams should develop plans for spreading improvements from the very beginning. Strategies for spread may include[2]:

- Engage leadership in the spread.
  - Ensure transitions of care are a key strategic initiative, goals and incentives for the work are aligned, and an executive leader is assigned.
- Define the improvement ideas and communicate with the broader care team.
  - Identify target patient population and adopter groups, involve key partners, and develop an initial spread strategy.
- Communication
  - Promote awareness of the improvement and technical support available.
- Organizational culture
  - Form communities of practice, make technical support available, seek support from the PCN and zone.
- Measure and solicit feedback.
  - Capture throughout the tests of change and compile so that it can be effectively communicated to others – supporting decision making.

Additionally, after successful implementation with the initial population of patients, the improvement team can work to spread learning and changes to other aligned topics. Creating processes for this patient population supports care teams in developing processes for a wide range of paneled patients. Other processes that involve care coordination in the health neighbourhood include Reducing the Impact of Financial Strain and Opioid Process Improvements.

7 Celebrate

It is often easy as an improvement team to see your PDSA cycles as items on your checklist. Once complete, teams quickly jump to the next process improvement activity. However, it is important to plan to celebrate at milestones along the improvement journey, as well as when you achieve your aim. If you recognize and highlight the efforts and accomplishments of the team, this will go a long way to ensure staff stay motivated and engaged.

References

1. Scoville R, Little K, Rakover J, Luther K, Mate K. ***Sustaining improvement***. IHI white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at www.IHI.org)
2. Massoud MR, Nielsen GA, Nolan K, Schall MW, Sevin C. ***A framework for spread: from local improvements to system-wide change.*** IHI innovation series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2006. (Available at www.IHI.org)

Appendices

Appendix A: Sequence to Achieve Change Workbook

Appendix B: H2H2H Potentially Better Practices: Rationale and Evidence document

Appendix C: Patient Partner on an Improvement Team guide