Dialogue Summary

Improving Hospital-to-home Transitions for Older Adults with Complex Health and Social Needs in Ontario

9 & 10 December 2020

EVIDENCE >> INSIGHT >> ACTION

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McMaster Health Forum

The McMaster Health Forum's goal is to generate action on the pressing health- and social-system issues of our time, based on the best available research evidence and systematically elicited citizen values and stakeholder insights. We aim to strengthen health and social systems – locally, nationally, and internationally – and get the right programs, services and drugs to the people who need them.

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

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Dialogue

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SUMMARY OF THE DIALOGUE

The deliberation initially focused on the most important challenges in improving hospital-to-home transitions for older adults with complex health and social needs in Ontario, with the first priority being a significant re-framing of the problem (or goal) as described in the evidence brief and the other challenges complementing this re-framing:
- transitions should be framed from a continuum-of-care perspective;
- achieving optimal transitions requires new key performance indicators that reflect an understanding of the person and their health and social context;
- funding arrangements should enable the achievement of these key performance indicators; and
- new indicators and funding arrangements need to be accompanied by different types of leadership.

Much of the deliberation about potential elements of a way forward focused on enabling decision-makers to make small yet rapid changes to improve the quality of hospital-to-home transitions (element 3), with less discussion focused on enabling providers to improve the quality of hospital-to-home transitions (element 2), and less again on enabling older adults and their caregivers to play a role in their own care during hospital-to-home transitions (element 1). Participants emphasized that:
- we need to get the key performance indicators right;
- then, we (likely) need to get the funding arrangements right at all levels (and support learning with dashboards);
- we also need to recognize that funding affects structures, and structures affect practices (and that these connections are influenced by business models and by work processes used in care organizations); and
- we need to optimally integrate virtual care alongside in-person care.

Many dialogue participants emphasized the need to recognize that the onus is on providers and system leaders to get this right, but that we can support older adults and caregivers by drawing on and augmenting what they know (mind), understanding and helping them address how they feel (heart), and engaging them in what they can do (hand) – and being transparent about why providers and leaders do what they do.

When discussing implementation considerations most participants acknowledged two major barriers to moving forward: 1) the COVID-19 pandemic that "sequestered the system;" and 2) the front-line providers not playing a key leadership role in system transformation. However, they identified four features of the current landscape that could collectively create a window of opportunity to improve hospital-to-home transitions for older adults:
- the creation of Ontario Health Teams;
- the recent quality standards for hospital-to-home transitions in Ontario;
- the shared health priorities endorsed by the federal/provincial/territorial governments in 2017 and later operationalized by the Canadian Institute of Health Information as a series of indicators; and
- the opportunity to raise awareness and mobilize nurses, personal-support workers, and other front-line providers to play a leadership role to bring about change.

Participants prioritized several actions as next steps in improving transitions in care for older adults with complex health and social needs in Ontario, including: creating a call to action to respond to the COVID-19 pandemic in a way that strengthens the entire system; amplifying the voices of clients, families and caregivers to share their experiences and solutions to improve hospital-to-home transitions; and strengthening research and training capacities to support health-system transformations (e.g., supporting Advanced Clinical Practice Fellows embedded in OHTs; developing best practice guidelines from a person-centred lens; and developing resources to help OHTs to better understand their community).

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

The deliberation focused on the most important challenges in improving hospital-to-home transitions for older adults with complex health and social needs in Ontario, with the first priority being a significant re-framing of the problem (or goal) as described in the evidence brief and the other challenges complementing this re-framing:
- transitions should be framed from a continuum-of-care perspective;
- achieving optimal transitions requires new key performance indicators that reflect an understanding of the person and their health and social context;
- funding arrangements should enable the achievement of these key performance indicators; and
- new indicators and funding arrangements need to be accompanied by different types of leadership.

Transitions should be framed from a continuum-of-care perspective

Several participants initiated the deliberation by emphasizing that "hospital-to-home transitions" (as presented in the evidence brief) should be re-framed. They pointed out that transitions should not be framed from the perspective of a hospital, which is a 'pit stop' in any patient journey. As one participant indicated: "It is framed as getting you out of the hospital. [...] The starting point should be keeping the clients in the community in the first place."

They also indicated that we need to acknowledge that there are "different journeys" and "different homes," and that not all clients have family support. For instance, many older adults with complex health and social needs also experience mental health and addiction problems, as well as homelessness. Therefore, some clients may experience "hospital-to-street" transitions.

Participants generally agreed that transitions should be framed from a continuum-of-care perspective. They indicated that supports for any such transitions should:
- focus on life care, not just healthcare and social services;
- build on client strengths;
- be grounded in strong home- and community-care programs and in primary care;

Box 1: Background to the stakeholder dialogue

The virtual stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:
1) it addressed an issue currently being faced in Ontario;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three elements of a potentially comprehensive approach for addressing the policy issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three elements of an approach to addressing it, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach to addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed;" and
10) it did not aim for consensus.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health- and social-system leaders typically need to engage elected officials, boards of directors and others about detailed commitments.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

- involve shared goals and responsibilities across providers in a client's circle of care;
- adopt realistic expectations (e.g., about in-home support needed and available, readiness to transition, and transition success);
- emphasize relationships and relational continuity (not transactions or tasks); and
- be flexible to respond to the specific needs of each client.

Dialogue participants recognized that promoting such re-framing in the context of the COVID-19 pandemic may be challenging. According to participants, when COVID-19 hit the province it created a panic and shifted the entire focus onto hospitals and long-term care homes. It left the home- and community-care sector destabilized, with limited access to personal protective equipment and a loss of staff to hospitals and public-health departments offering higher pay. The pandemic revealed long-standing issues in the home- and community-care sector. As one participant indicated about the home- and community-care sector: "There were long-standing equity problems. We don't have the enablers. We don't have access to patient information. We have wage disparities. We have the deepest and most direct relationship with clients but limited links to primary-care providers. We are such a tiny part of health-system funding. We need [...] home and community care [to be] more technology enabled and supported."

Achieving optimal transitions requires new key performance indicators that reflect an understanding of the person and their health and social context

Participants agreed that achieving optimal transitions requires new key performance indicators, such as keeping people in their desired home and doing so in a way that reflects an understanding of the person (e.g., ethnocultural background and socio-economic status) and their health and social context (e.g., their home may be the street, a shelter, supportive housing, a retirement home, or an apartment).

Several participants indicated that Ontario Health Teams (OHTs) could play a crucial role in developing new key performance indicators. As one participant said: "It's been an interesting first year [for OHTs] that has been eclipsed by COVID. [However,] we are figuring out [how] to be more effective with establishing metrics."

The key performance indicators should:
- be developed collaboratively (with patients, caregivers, and families);
- measure patient, caregiver and family experiences, as well as patient outcomes;
- unpack the entire patient journey (some problems may occur several days or weeks after hospital discharge); and
- support real-time data analytics.

Funding arrangements should enable the achievement of these key performance indicators

Participants emphasized that funding arrangements should enable the achievement of these key performance indicators. This includes adjusting the amounts of funds, the design of the arrangements, and the relationship between these arrangements and arrangements in other sectors that contribute to wage disparities. As one participant said: "We are going against the grain with atypical indicators." Participants noted that how groups are incentivized will be critical.

New indicators and funding arrangements needs to be accompanied by different types of leadership

Participants indicated that new indicators and funding arrangements need to be accompanied by different types of leadership. This included leadership from community-based organizations, from front-line staff and from patients and families that allows for the dynamic matching of supports to the changing needs of each patient.

A few participants pointed out that the leadership of some OHTs is still hospital-centric. This may be explained, in part, by the fact that hospitals had the in-kind resources to get the OHTs started. To achieve a

change in leadership, several participants called for a movement "to move the boundaries," or "to flip the system on its head." One participant remained confident about bringing about change and indicated that some OHTs were moving towards community-based leadership.

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH

Much of the deliberation about potential elements of a way forward focused on enabling decision-makers to make small yet rapid changes to improve the quality of hospital-to-home transitions (original element 3 in the evidence brief that informed the stakeholder dialogue), with less attention given to enabling providers to improve the quality of hospital-to-home transitions (original element 2), and less again to enabling older adults and their caregivers to play a role in their own care decisions during hospital-to-home transitions (original element 1).

Original element 3 - Enabling decision-makers to make small yet rapid changes to improve the quality of hospital-to-home transitions

The deliberation about the third element focused on an approach called 'rapid-learning systems.' Decision-makers would be able to make small yet rapid changes to improve the quality of hospital-to-home transitions for older adults with complex health and social needs. Decision-makers at all levels (from those working in local organizations delivering care to those working in government) could try new approaches, rapidly evaluate them in 'real time', and quickly adjust the approach when necessary.

This element resonated with participants, many of whom emphasized the need to tackle system challenges, and to "turn the system on its head." As one participant said: "The system reproduces the system. We have designed the system to create the problem."

To achieve this, participants emphasized four things:
- we need to get the key performance indicators right (as noted in the problem section);
- then we (likely) need to get the funding arrangements right at all levels (and support learning with dashboards);
- we also need to recognize that funding affects structures, and structures affect practices (and that these connections are influenced by business models and by work processes used in care organizations); and
- we need to optimally integrate virtual care alongside in-person care.

First, the bulk of the conversation focused on the need to get the key performance indicators right. The key performance indicators should:
- include metrics along the entire client journey and continuum of care;
- help to predict what may happen next (and what could be the alternatives);
- start with the care priorities and preferences identified by clients, families and caregivers (e.g., keep people in their preferred 'home' or document how clients, families, caregivers and providers feel supported and enabled);
- be shared with providers on a daily basis via dashboards;
- be accessible to front-line providers;
- be for Ontario Health Teams and for the entire province; and
- support shared accountability across the care team.

Second, participants indicated that we (likely) need to get the funding arrangements right at all levels (and support learning with dashboards accessible to front-line providers). However, a few participants indicated that the conversation was stimulating but overwhelming, and that they needed a better understanding about

what current funding arrangements achieve right now, before thinking about redesigning those arrangements. This resonated with one participant who said: "As a front-line provider, I don't know how the funding discussions affect my everyday practice."

Third, participants emphasized the need to recognize that funding affects structures and structures affect practices (and that these connections are influenced by business models and by work processes). One participant pointed out the importance of raising awareness about the interplay of funding arrangements, structures, practices, and work-process models: "A lot of people do not understand the details because they haven't run [a] business in the system."

Lastly, some participants indicated that a big challenge ahead, from a system perspective, will be how to optimally integrate virtual care alongside in-person care. Virtual care could be seen as both an enabler and barrier to hospital-to-home transitions. As one participant said: "Location isn't everything. With COVID, we turned to virtual in 24 hours. [But we need to think about] rural and hard-to-service areas. We need to be careful how we design virtual care. Access to care can come in so many different ways. We need standards." A second participant highlighted that the recent quality standards published in Ontario about hospital-to-home transitions addressed the integration of virtual care and in-person care and could provide a strong basis for moving forward.

Original element 2 - Enabling providers to improve the quality of hospital-to-home transitions

The second element focused on identifying strategies to support individual providers (or providers working as a team) to improve the quality of hospital-to-home transitions.

Participants indicated that members of the care team should anticipate and plan for future needs and, when hospital admission is needed, the team needs to start planning for discharge at admission (which includes understanding the 'home' that patients will return to). Some participants emphasized that care transitions should be planned prospectively. As one participant said, the team planning the care transitions should think about "the next disease deterioration so that it doesn't turn into a hospitalization."

Participants also highlighted the need to empower front-line providers to flexibly translate best-practice guidelines to each patient (and to work collaboratively with other healthcare providers and with broader human-service providers, including those working within municipal governments). One participant said: "We can't think in a linear way. We need flexibility with the individual, the family, and the front-line providers." A second participant emphasized: "Successful transitions often rely on non-health related resources, such as shelters, food banks, municipal services. COVID helped to have that conversation. But that's a different bureaucracy."

Original element 1 - Enabling older adults and their caregivers to play a role in their own care during hospital-to-home transitions

The first element focused on strategies to enable older adults with complex health and social needs (and their caregivers) to play a role in their own care decisions during hospital-to-home transitions (and well beyond the post-discharge period).

Many dialogue participants emphasized the need to recognize that the onus is on providers and system leaders to get this right, but that we can support older adults and caregivers by drawing on and augmenting what they know (mind), understanding and helping them address how they feel (heart), and engaging them in what they can do (hand) – and being transparent about why providers and leaders do what they do. As one participant said: "We could empower them if we had a system that made sense. The main responsibilities lie with us, not with them. The system failed, not them. The onus is on us. [Patients and caregivers] have enough responsibility."

They also indicated that we need to identify and document caregivers and see them as a knowledgeable resource and partner. As one participant said, "the biggest angst of hospital providers" is that they often do not know who the patient's caregiver is and they do not know who to turn to in order to determine if the patient has all the support needed at home. A second participant went further: "Caregivers come with an awful lot of knowledge. No provider can capture their entire experience. The care team often doesn't see [caregivers] as a resource."

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

When discussing implementation considerations, most participants acknowledged two major barriers to moving forward: the COVID-19 pandemic and leadership. They emphasized that "the pandemic sequestered the system" and that it returned "us back to reproduce the system we wanted to change." They illustrated this by referring to the hospital takeover of long-term care, as well as the army-led and hospital-centred vaccine delivery that is bypassing primary care and home and community care. Nonetheless, some participants highlighted that promising models of care emerged during the pandemic, like the CovidCare@Home model. But one participant indicated that this model was only possible because front-line providers were able to play stronger leadership: "This [model] was possible because we were at the table. We need to create this environment in Ontario Health Teams."

Having discussed barriers, participants identified four features of the current landscape that could collectively create a window of opportunity to improve hospital-to-home transitions:

- the creation of Ontario Health Teams (OHTs) will need key performance indicators, and a task force is expected to be created to figure out how funding arrangements and key performance indicators could be aligned);
- the recent quality standards for hospital-to-home transitions;
- the shared health priorities endorsed by the federal/provincial/territorial governments in 2017 and later operationalized by the Canadian Institute of Health Information (CIHI) as a series of indicators; and
- the opportunity to raise awareness and mobilize nurses, personal-support workers, and other front-line providers to play a leadership role to bring about change.

Regarding the third bullet point about CIHI, one participant noted: "They were under the gun to get consensus. They started with 500 indicators and then boiled them [down] to five. CIHI could inform the process of getting there." Regarding the fourth bullet point about front-line providers, another participant observed: "They don't have a clue about what is at happening at the system level. Our biggest potential is to empower front-line providers to answer the call of the people they take care of."

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

In the deliberations about next steps, participants outlined what they would bring back to their respective constituencies and how their suggestions could work to advance the proposed solutions. Together, participants prioritized several actions to improve transitions in care for older adults with complex health and social needs in Ontario:

- creating a call to action to respond to the COVID-19 pandemic in a way that strengthens the entire system;
- amplifying the voices of clients, families and caregivers to share their experiences and solutions to improve hospital-to-home transitions; and
- strengthening research and training capacities to support health-system transformations (e.g., supporting Advanced Clinical Practice Fellows embedded in OHTs; developing best-practice guidelines from a person-centred lens; and developing resources to help OHTs to better understand their community).

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