Path to Home Passport – Have You Got Your Passport?

Best Practice Day 2018
Chestnut Conference Centre – Toronto, ON

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Presenter: Harvinder Singh BSc.Phm, PharmD, RPh
Outline

- **About** Bruyère Continuing Care
- **Rationale** for development of the Path to Home Passport
- **Development** of the Path to Home Passport
  - Partnering with PODS
- **Implementation** of the Path to Home Passport
- **Future Steps**
  - APP development
About Us

- Located in Ottawa, Ontario
  - Over 170 years of care

- Multi-site
  - Élisabeth Bruyère Hospital (EBH)
  - Saint-Vincent Hospital (SVH)
  - Élisabeth Bruyère Residence
  - Residence Saint-Louis
  - Bruyère Village

- 731 beds
  - 227 independent and assisted living units

- Bruyère Research Institute
About Us

- Geriatric rehabilitation
- Stroke rehabilitation
- Palliative care
- Outpatient ambulatory clinics

Élisabeth Bruyère Hospital
About Us

- Low intensity rehabilitation
- Dialysis
- Wound Management
- Supportive Care
- ALC

Saint-Vincent Hospital
Our patient population is changing:

- **Shorter** lengths of stay
- **Increased complexity** with multiple co-morbidities
- **Increase patient flow** with increased admissions and discharges
  - Discharge process more important now more than ever before
The idea for our Path to Home Passport came from:

- **Kaizen Event** (SVH)
  - Participation in a Canadian Foundation for Healthcare Improvement’s collaborative “Partnering with Patients and Families for Healthcare Improvement”

**Transitions of Care**

**At the Bedside**
Rationale

The idea for our Path to Home Passport came from:

Patient Feedback Data
- Complaints
- Satisfaction Survey

Best Practice Data
- BRI collaboration
- Improves patient/caregiver experience
Many patients and their caregivers do not understand or remember the discharge instructions that they are given in hospital.

- Create a **patient-owned tool** that the care team facilitates the completion of

- Create a tool that is written in **plain language** and is easy to understand
Patients and caregivers often do not know what questions to ask the care team to prepare for going home.

- Create a tool based on best practices to prompt discussion and answers to the questions more important to the patient and their caregiver.
Patients and caregivers are provided with a large amount information just before going home and do not have time to process it

- Create a tool that is introduced early and is completed throughout the patients stay in hospital

- Create a tool where additional information and educational materials provided by the care team can be consolidated
Rationale

- Better **prepare** our patients for discharge
- Improve **safety** of patients who are being discharged
- Improve **dialogue** between patients and care team
- Improve the **overall discharge experience** for our patients
In designing the PTHP it was important for us to:

- **Partner with our patients** and their caregivers in co-design
- Use **evidence based practices**:
  - Re-engineered Discharge
  - NHS Discharge Passport
  - Patient Oriented Discharge Summary
- Put the **needs of the patient at the center**
- Provide **written** discharge instructions
Process of Development

- **Step 1**: Establish a planning group
- **Step 2**: Identify the purpose and the intended audience
- **Step 3**: Assess available materials
- **Step 4**: Decide on the content
- **Step 5**: Write the information in plain language
- **Step 6**: Apply a clear design
Process of Development

- **Step 7:** Get feedback from the clinical team
- **Step 8:** Get feedback from patients and families
- **Step 9:** Get approval
- **Step 10:** Produce the material
- **Step 11:** Distribute and use the material
- **Step 12:** Evaluate the material
Step 1: Establish a Planning Group

- Meet every 2 weeks for 5 months
Who do you think should be included in the process of development?
Development

Path to Home Passport Working Group

Marion and Ron Whiting: Patient and Family Advisors
Development

Path to Home Passport Working Group
Development
Path to Home Passport Working Group

Patients and families

Health care providers

Patient education specialist
Patient Education Specialist contribute expertise related to:

- **Plain language and clear design**
- Health education and adult learning theories
- Patient-centered education
- Production of patient education materials
Step 2: Identify the purpose and the intended audience

- Do you want to help patients:
  - Increase **awareness** or **knowledge**?
  - Develop or improve **skills** (self-care, problem-solving)?
  - Change a specific **health behaviour**?
  - Increase their **self-confidence** or decrease their **anxiety**?
Step 2: Identify the purpose and the intended audience

- Do you want the material to be used:
  - As a tool during **health teaching** with a health care provider?
  - Daily, at home, to **monitor progress** towards a goal?
  - Occasionally, as **reference** material?
  - As a **guide**, before making a decision regarding a treatment?
Step 2: Identify the purpose and the intended audience

- Rehabilitation patients who are going home
Step 3: Assess available materials

- RED (Re-Engineered Discharge)
  - Boston

- PODS (Patient Oriented Discharge Summary)
  - Toronto

- Health Passport
  - England (UK)
The patient-oriented discharge summary (PODS) is a simple tool that arms patients with 5 key pieces of information they need to know in order to effectively manage their health after a hospital discharge:

- **S**igns and symptoms to watch out for
- **M**edication instructions
- **A**ppointments
- **R**outine and lifestyle changes
- **T**elephone numbers and info to have handy
Results showed that patient satisfaction scores related to discharge experience increased between 9.3% and 19.4% after PODS implementation.

Design Involved:
- 56 patients and caregivers
- 30 health-care personnel
- 7 patient education professionals and 8 designers

PODS was designed by OpenLab at the University Health Network, with support by the Toronto Central LHIN.
Development

My Care Guide
I came to hospital on 01/29/2016 and left on 01/31/2016
I came in because I have

Medications I need to take
My medications, their purpose and possible side effects, have been explained to me.

How I might feel and what to do
How I am feeling: What to do:

Changes to my routine
Activity Instruction
Exercise

Appointments I have to go to
Go see family doctor for on 01/31/2016 at 2:00 pm
Location: (12) 456-7890 booked

Where to go for more information
For Any questions call/go to Patient navigator
For Any questions call/go to
For Any questions call/go to
For call/go to
# Development

## This is my Hospital Passport

For people with learning disabilities coming into hospital

*My name is:*

If I have to go to hospital this book needs to go with me. It gives hospital staff important information about me.

It needs to hang on the end of my bed and a copy should be put in my notes.

*This passport belongs to me. Please return it when I am discharged.*

Nursing and medical staff please look at my passport before you do any interventions with me.

- Things you must know about me
- Things that are important to me
- My likes and dislikes

---

## Things you must know about me

| Name: | 
| Likes to be known as: | 
| NHS number: | 
| Date of Birth: | 
| Address: | 
| Tel No: | 

*How I communicate/What language I speak:*

*Family contact person, carer or other support:*

- Relationship e.g. Mum, Dad, Home Manager, Support Worker:
- Address:
- Tel No:

*My support needs and who gives me the most support:*

*My carer speaks:*

*Date completed by:*

---

*Spire and St Helier University Hospitals NHS Trust*

*Kingston Hospital NHS Trust*

*Mayday Healthcare NHS Trust*

*St Georges Healthcare NHS Trust*

*Foundation of Nursing Studies*

*Crabbon Community Learning Disability Team*

*Kingston Community Learning Disability Teams*

*Merton Team for People with Learning Disabilities*

*Richmond Specialised Healthcare Team (Learning Disabilities)*

*Sutton Learning Disabilities Team*

*Walworth Community Learning Disability Team*
Development

Things that are important to me

- How to communicate with me:
- How I take medication: (whole tablets, crushed tablets, injections, syrup)
- How you know I am in pain:
- Moving around: (Posture in bed, walking aids)
- Personal care: (Dressing, washing, etc)

Things that are important to me

- Seeing/ Hearing: (Problems with sight or hearing)
- How I eat: (Food cut up, pureed, risk of choking, help with eating)
- How I drink: (Drink small amounts, thickened fluids)
- How I keep safe: (Bed rails, support with challenging behaviour)
- How I use the toilet: (Continence aids, help to get to toilet)
- Sleeping: (Sleep pattern routine)
Development

My likes and dislikes

Likes: for example - what makes me happy, things I like to do 
I.e. watching TV, reading, music, routines.

Dislikes: for example - don’t shout, food I don’t like, physical touch.

Things I like
Please do this:

Things I don’t like
Don’t do this:

Notes

Date completed by

Bruyère
CONTINUING CARE
Contacts and useful websites

Community Learning Disability Teams (CLDT)
Croydon Community Learning Disability Team
(020) 8230 4444/4442

Kingston Community Learning Disability Team
(020) 8547 6558
email: cldt@rbk.kingston.gov.uk

Lambeth Community Learning Disability Team
(020) 7920 5555

Merton Team for People with Learning Disabilities
(020) 8545 4404/4545

Richmond Specialist Healthcare Team (Learning Disabilities)
(020) 8487 5515

Sutton Learning Disabilities Team
(020) 8770 6080

Wandsworth Community Learning Disability Team
9.30am to 2pm Monday to Friday (020) 88125270
Between 2.30pm and 9.30am 07957361977
Out of hours 8am to 8pm and weekends (020) 8871 6000

www.easyhealth.org.uk
www.intellectualdisability.info
www.mencap.org.uk/gettinginright

Please contact your local community learning disability team
if you have any questions about the passport

This Hospital Passport was developed by the South West London Access to Acute Group, and based
on original work by Gloucestershire Partnership NHS Trust.

Thank you to The Slated Oak Theatre Company, members of our community, Wandsworth
Community Learning Disability Team, staff of the St. George's Hospital Acute Working Group,
Merton CIPDU Community Nurses and the Corporate Design department at Wandsworth Council who
all helped in the redesign of this document.
The RED consists of a set of 12 mutually reinforcing actions (as outlined in the box below) that the hospital undertakes during and after the hospital stay to ensure a smooth and effective transition at discharge.

**Components of the RED**

1. Ascertaining need for and obtaining language assistance.
2. Making appointments for follow-up care (e.g., medical appointments, postdischarge tests/labs).
3. Planning for the follow-up of results from tests or labs that are pending at discharge.
4. Organizing postdischarge outpatient services and medical equipment.
5. Identifying the correct medicines and a plan for the patient to obtain them.
6. Reconciling the discharge plan with national guidelines.
7. Teaching a written discharge plan the patient can understand.
8. Educating the patient about his or her diagnosis and medicines.
9. Reviewing with the patient what to do if a problem arises.
10. Assessing the degree of the patient's understanding of the discharge plan.
11. Expediting transmission of the discharge summary to clinicians accepting care of the patient.
12. Providing telephone reinforcement of the discharge plan.
Development

Why Should Hospitals Use the RED?

Improves Clinical Outcomes

• Decreases 30-day readmission by 25 percent.
• Decreases ED use from 24 percent to 16 percent.
• Improves patient "readiness for discharge."
• Improves primary care provider followup.

Meets Safety Standards and Improves Documentation

• Accepted as NQF Safe Practice and endorsed by Institute for Healthcare Improvement, The Leapfrog Group for Patient Safety, and CMS
• Meets Joint Commission standards.
• Documents the discharge preparation.
• Documents understanding of the discharge plan.

Improves Return on Investment

• Reduces costs by $412 per patient.
• Allows higher level physician billing for discharge.
• May reduce diversion and creates greater capacity for higher revenue patients.
• May improve market share as "preferred provider."
• Improves relationships with ambulatory providers.
• Prepares for changes in CMS rules regarding readmission reimbursement.

Improves Patient Centeredness and Hospital’s Community Image

• Brands the hospital as high-quality facility.
• Improves patient and family satisfaction.
The “After Hospital Care Plan” (AHCP) is an essential component of the RED

- It is a spiral-bound, colour booklet
- Presents information for patients that they will need to prepare them for the days between discharge and their first visit with their ambulatory care physician
- It was designed with the assistance of graphic design and health literacy consultants so that the information is presented in a clear and understandable format, using large fonts, colors, and icons.
Components of After Hospital Care Plan (AHCP)

AHCP Example: Cover Page

Bring This Plan to ALL Appointments

After Hospital Care Plan for:

Oscar Sanchez

Discharge Date: August 1, 2012

Personalized:
- Name
- Date
- Phone numbers

TRY TO QUIT SMOKING: Call Jon Doe at (xxx) xxx-xxxx at ABC Medical Center.

Question or Problem with this Packet? Call your Discharge Educator: (xxx) xxx-xxxx

Serious health problem? Call Dr. Mark Avery: (xxx) xxx-xxxx
### AHCP Example: Medicine Schedule

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Why am I Taking this Medicine?</th>
<th>Medicine Name and Amount</th>
<th>How Many (or How Much) Do I Take?</th>
<th>How do I Take this Medicine?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td>Blood pressure</td>
<td>PROCARDIA XL NIFEDIPINE 90 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td></td>
<td>Blood pressure</td>
<td>HYDROCHLOROTHIAZIDE 25 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td></td>
<td>Blood pressure</td>
<td>CLONIDINE HCl 0.1 mg</td>
<td>3 pills</td>
<td>By mouth</td>
</tr>
<tr>
<td></td>
<td>Cholesterol</td>
<td>LIPITOR ATORVASTATIN CALCIUM 20 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td></td>
<td>Stomach</td>
<td>PROTONIX PANTOPRAZOLE SODIUM 40 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
</tbody>
</table>

**Individualized:**
- **Timing:**
- **Rationale:**
- **Medicine:**
- **Dose:**
- **Route:**

*SOINS CONTINUS CONTINUING CARE*
<table>
<thead>
<tr>
<th>What is my main medical problem?</th>
<th>Oscar Sanchez</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When are my appointments?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appointment:</strong></td>
</tr>
<tr>
<td>----------------------------</td>
</tr>
<tr>
<td><strong>Wednesday, August 8th</strong></td>
</tr>
<tr>
<td>at 11:30 am</td>
</tr>
<tr>
<td>100 Main St., 2nd Floor</td>
</tr>
<tr>
<td><strong>For a Followup appointment</strong></td>
</tr>
<tr>
<td><strong>Office Phone #:</strong></td>
</tr>
<tr>
<td>(555) 555-5555</td>
</tr>
</tbody>
</table>

*SOINS CONTINUS*  
BRUYère  
CONTINUING CARE
## AHCP Example: Additional Information

**What exercises are good for me?**

Walk for at least 20 minutes each day.

**What should I eat?**

Eating food that is low in fat and low in cholesterol will help you stay healthy.

**What are my medicine allergies?**

REMEMBER you are ALLERGIC to MOTRIN.

**Where is my pharmacy?**

Joe’s Pharmacy  
1234 Summertime Ave.  
Anytown, ST 55555  
(555) 555-7777
Development

AHCP Example: Patient Activation Page

Questions for Dr. Avery
For my appointment on Wednesday, August 8th at 11:30 am

Check the box and write notes to remember what to talk about with Dr. Avery

I have questions about:
☐ my medicines _____________________________
☐ my pain _________________________________
☐ feeling stressed __________________________
☐ What other questions do you have? __________________

Tell Dr. Avery: When I left the hospital, results from an examination of stomach tissue to look for H. pylori were not available. Please check for results of these tests.
# Development

## AHCP Example: Appointment Calendar

### August 2012

<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Delivery of Bed by Martin Inc. 555-5555-5555</td>
<td>Followup phone call</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dr. Avery at 11:30 am 100 Main St. 2nd Floor, Anytown, ST</td>
<td>N.E. VNA to visit 555-5555555</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dr. Jones at 3:20 pm, 100 Pleasant Rd., Suite 105, Anytown, ST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
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<tr>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
</tr>
</tbody>
</table>
AHCP Example: Diagnosis Information

My Medical Problem

**Noncardiac Chest Pain**

Noncardiac chest pain is pain that is not caused by a heart problem.

- If your chest pain gets different or worse, call your doctor.
- Take your medicines as prescribed.
- See your doctor and ask questions.
The “After Hospital Care Plan” (AHCP) is an essential component of the RED

- Creation of the AHCP is now **automated** by means of a Discharge Planning Workstation
- Once this information is entered, the **workstation automatically creates a draft AHCP**
- The **discharge nurse then reviews and refines this plan**, if necessary
- Following this, the **discharge nurse prints out the draft** discharge plan and takes it to the **physician for review and sign-off**
The “After Hospital Care Plan” (AHCP) is an essential component of the RED

- Once the discharge plan has been finalized, it is “published” and a spiral binding is added at the workstation

- The **discharge advocate then teaches the information** it contains to the patient at his/her bedside

- Future goal is to integrate the workstation into the hospital’s electronic health record (EHR) system
What are some differences that you noticed between the 3 patient tools we reviewed?
What are some similarities that you noticed between the 3 patient tools we reviewed?
Step 4: Decide on Content

- Front line staff were included in working group
  - Can comment on what they think is important to convey to patients

- **Patient input – most valuable**
  - What information **did they want** included?
  - Did they **see value in the information** the front line staff saw as important?

- **PODS – Evaluation Study Participation**
  - Had to include certain sections to be included in study

- Had reviewed other patient discharge tools
Step 5: Write information in plain language

Step 6: Apply clear design
Development

Writing
health information
for patients and families

A guide to developing educational materials that promote health literacy

Lindsay Wizowski · Theresa Harper · Tracy Hutchings

SOINS CONTINUOUS
Bruyère
CONTINUING CARE
What is health literacy?
Health literacy is the ability to access, understand and use health information. It emerges from the interaction between a person, his or her environment and the health care system.
## Part One

<table>
<thead>
<tr>
<th>Question</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the benefits of using patient education materials?</td>
<td>5</td>
</tr>
<tr>
<td>Why develop patient education materials?</td>
<td>7</td>
</tr>
<tr>
<td>Why develop materials when patients can access health information on the Internet?</td>
<td>9</td>
</tr>
<tr>
<td>What is the most effective way to use patient education materials?</td>
<td>11</td>
</tr>
<tr>
<td>What is the process for developing patient education materials?</td>
<td>14</td>
</tr>
</tbody>
</table>
### Part Two

<table>
<thead>
<tr>
<th>Question</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is health literacy?</td>
<td>16</td>
</tr>
<tr>
<td>What influences health literacy?</td>
<td>19</td>
</tr>
<tr>
<td>What is the difference between literacy and health literacy?</td>
<td>20</td>
</tr>
<tr>
<td>How ‘health literate’ are Canadians?</td>
<td>21</td>
</tr>
<tr>
<td>Why does health literacy matter?</td>
<td>23</td>
</tr>
<tr>
<td>How can health literacy be measured?</td>
<td>24</td>
</tr>
<tr>
<td>What health literacy measures do you recommend?</td>
<td>29</td>
</tr>
<tr>
<td>What is a ‘universal precautions’ approach to health literacy?</td>
<td>30</td>
</tr>
<tr>
<td>What is plain language?</td>
<td>31</td>
</tr>
<tr>
<td>What is clear design?</td>
<td>42</td>
</tr>
<tr>
<td>What is important to consider when writing for the web?</td>
<td>54</td>
</tr>
<tr>
<td>What is important to consider when presenting numerical information?</td>
<td>58</td>
</tr>
<tr>
<td>Is it helpful to include references in patient education materials?</td>
<td>63</td>
</tr>
<tr>
<td>How is the quality of patient education materials assessed?</td>
<td>64</td>
</tr>
<tr>
<td>How can health professionals provide information to patients with limited English proficiency?</td>
<td>69</td>
</tr>
<tr>
<td>What websites provide multilingual health information?</td>
<td>69</td>
</tr>
<tr>
<td>What is the process for translating English materials?</td>
<td>72</td>
</tr>
<tr>
<td>How helpful are online translation tools?</td>
<td>75</td>
</tr>
<tr>
<td>When is it better to develop materials with the intended audience rather than provide materials translated from English?</td>
<td>76</td>
</tr>
</tbody>
</table>
Part Three

Developing patient education materials requires commitment and investment

The process of developing patient education materials

1. Establish a planning group
2. Identify the purpose and the intended audience
3. Assess available materials
4. Decide on the content
5. Write the information in plain language
6. Apply a clear design
7. Get feedback from the clinical team
8. Get feedback from patients and families
9. Get approval
10. Produce the material
11. Distribute and use the material
12. Evaluate the material
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Appendix B: Health literacy assessment tools  134

Tell us what you think!  140
## Checklist for patient education materials

Use these criteria to assess the suitability of material for patient and family education.

<table>
<thead>
<tr>
<th>Content</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the title clearly identify the topic or content?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the purpose of the material clearly stated at the beginning?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a table of contents to show how the material is organized?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Is the content divided into short sections or ‘chunks’ of information?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Does each section have a meaningful heading (a question or key message) that helps the reader find information?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the content organized in a way that makes sense to the reader and is easy to follow?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the content reflect current practice guidelines, research evidence and what is taught?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the content limited to the information of greatest interest to readers? (not medical facts or ‘nice-to-know’ information)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Does the content include action steps (what readers need to do)?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Are important points emphasized or summarized?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the material encourage interaction with the reader (Q&amp;A, quiz, checklist, blanks for responses, stories, quotes)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the material encourage readers to take an active role in their health care?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the material tell readers where to get help or more information?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the material free from bias and commercial endorsement?</td>
<td></td>
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</tr>
</tbody>
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<tr>
<th>Writing style</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tr>
<td>Is the material written in plain language - the familiar, everyday language of the readers?</td>
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<tr>
<td>Are medical and technical words, acronyms and abbreviations defined?</td>
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<td>Is the material written mostly in the active voice?</td>
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<td>Is the tone positive and encouraging (not formal or clinical)?</td>
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<tr>
<td>Is the writing style conversational, with personal pronouns (I, we, you)?</td>
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<tr>
<td>Is the average sentence length about 10 to 15 words?</td>
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<tr>
<td>Are numbers in the material clear and easy to understand?</td>
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<tr>
<td>Are there clear instructions or examples of numerical calculations?</td>
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<tr>
<th>Clear design</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tr>
<td>Is the format (card, information sheet, pamphlet, booklet) suitable for the way readers will use the material?</td>
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<td>Are there no more than 2 simple fonts?</td>
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<tr>
<td>Is the font for body text large enough for easy reading (12 to 14 pt)?</td>
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<td>Do fonts get larger from body text, to subheadings and headings?</td>
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<td>Are upper and lower case letters used (not all capitals)?</td>
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<tr>
<td>Is the line length comfortable? (70 characters, 10 to 14 words, 5&quot;)</td>
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<td>Is the text left justified, without hyphens?</td>
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<td>Is there enough white space around margins and between sections?</td>
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<td>Are bullets used to present lists?</td>
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<td>Are important points emphasized with bold or a box?</td>
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<td>Is a dark font used on a light background or non-glare paper?</td>
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<td>Does colour emphasize important information or guide the reader?</td>
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<tr>
<td>Is the design of each page consistent?</td>
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<tr>
<th>Visuals (Photos, line drawings, graphics, clipart, cartoons)</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Do visuals help explain the text or reinforce key messages?</td>
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<tr>
<td>Do visuals have clear captions and labels?</td>
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<td>Do visuals show people, activities and objects that are familiar, realistic, age-appropriate and positive to readers?</td>
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<tr>
<td>Do drawings have simple, clear lines without distracting details?</td>
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<tr>
<td>Are body parts shown within the context of the whole body?</td>
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</table>

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<thead>
<tr>
<th>Process of development</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tr>
<td>Has the content been reviewed by the relevant health professionals?</td>
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<tr>
<td>Has the material been tested with typical readers?</td>
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<tr>
<td>Has the material been reviewed by a patient education specialist or a person with experience in plain language writing?</td>
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<tr>
<td>Does the material identify the organization, logo and publication date?</td>
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</table>

For a percent score: Add number of ‘Yes’ responses, divide by (44 – number of N/A responses), then multiply by 100. The higher the score, the more suitable the material is for patient and family education.
**Template for a Patient/Family Evaluation Form**

(adapt to meet your needs)

Tell us what you think!
After reading [title] please respond to the following statements. Your answers and comments will help us improve the information.

<table>
<thead>
<tr>
<th>Comment</th>
<th>strongly disagree</th>
<th>strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The words are easy to read.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The information is easy to understand.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading this information was helpful.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The information helped me [understand, know...].</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The information helped me know how to [behaviour, skill].</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The information answered my questions.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Please list what other questions you have:</td>
<td></td>
<td></td>
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<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would recommend this information to other [patients, people with...].</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The [drawings, photographs, charts...] helped me understand the information.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please turn over →

---

I would have liked more information about:

| Comments |

I would have liked less information about:

| Comments |

Other comments and suggestions:

| Comments |

Thank you!
Step 7: Get feedback from clinical team

- After multiple iterations, draft was brought to different health care practitioners not on initial committee for review.
  - Ex. section regarding medication brought back to pharmacist group during department meeting for input on content, design, layout.

- Information was brought back to working group, and edits were made as necessary.
Step 8: Get feedback from patients and families

- Getting feedback from patients and families is the best way to validate that your material:
  - is readable
  - is presented clearly
  - is understood
  - contains the right information – what patients want to know
  - achieves its purpose

- Pilot/review with 5-10 patients and families on 4N rehab (SVH)
Path to Home Passport

Before you go home, you will receive your Path to Home Passport. We hope you find it a useful tool to help you start thinking about your return to home. Your unit social worker and your care team will walk you through your Passport. They will answer any questions you may have and make sure it works for you.

The Path to Home Passport was created together with patients, families, your care team, the Champlain Community Care Access Centre and the Bruyère Research Institute. We worked together to make sure that you have the right information, help you decide what you need, and prepare you to go home safely.

Bruyère Continuing Care believes in "Excellence in Care". Research shows that a well-planned return home can decrease your chance of going back to the hospital and help with your recovery. We also want to make sure that you know how to take your medicine, and understand your other needs when you return home.

Our vision at Bruyère Continuing Care is to "Enhance Lives and Transform Care". We look forward to continue to work with our patients, families and partners on projects like this.

For more information, please talk to your Social Worker and visit our Path to Home E-Resources Website at http://www.bruyere.org/en/path-home-resources

Thank you,

Debbie Gravelle RN BScN MBS
Senior VP Clinical programs,
Chief Nurses Executive and
Chief of Allied Health
Development

All about Me

My Hospital
- Saint-Vincent Hospital
- Elisabeth Bruyère Hospital

My Location in the Hospital
- My Room number is: ____________________________
- My Clinical Manager is: __________________________
- Phone Number: __________________________

My Support Person
- Name: __________________________
- Relationship: __________________________
- Phone Number: __________________________
- My reason for being in hospital: __________________________

The Date I came to the Hospital: __________ / __________ / __________

The Date I Plan to Leave the Hospital: __________ / __________ / __________

Things that are Important to Me
My Hospital Care Team and Their Roles

- My Caregiver / Family
- Clinical Manager
- Nurse
- Doctor
- Occupational Therapist
- Speech Language Pathologist
- Respiratory Therapist
- Therapeutic Recreational Therapist
- Spiritual Services
- Dietitian
- Physiotherapist
- Hospital Pharmacist
- CCAC Care Coordinator
- Volunteers

I have received my Care Team Roles and Contact List.

My Medications

Before I leave the hospital:
- I have met with my hospital pharmacist.
- I have received a copy of my discharge prescription.
- I have reviewed my discharge prescription with my hospital pharmacist.
- I know what my medications are for.
- I know how and when to take my medications.
- I am aware of the potential side effects of my medications.
- I know the changes in medications that have been made since being in hospital.

After I leave the hospital:
- To package my medications, I would like my community pharmacy to use:
  - Blister / bubble packaging
  - Regular medications bottles
- I would like my medications to be delivered to where I will be staying.

My Community Pharmacy

Name:

Address:

Phone #:
## My Health Care Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Can I do this on my own?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Sugar Monitoring</td>
<td></td>
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<tr>
<td>Insulin Injections</td>
<td></td>
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<tr>
<td>Blood Pressure Monitoring</td>
<td></td>
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<tr>
<td>Pain Monitoring</td>
<td></td>
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<tr>
<td>Using Equipment</td>
<td></td>
</tr>
<tr>
<td>Other</td>
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<td>Other</td>
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<td>Other</td>
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<td>Other</td>
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</tbody>
</table>

## Recommended Lifestyle Changes

<table>
<thead>
<tr>
<th>Lifestyle Change</th>
<th>Is there a change?</th>
<th>Instructions</th>
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</thead>
<tbody>
<tr>
<td>Diet</td>
<td></td>
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<tr>
<td>Activity Level</td>
<td></td>
<td></td>
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<tr>
<td>Exercises</td>
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<tr>
<td>Other</td>
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<td>Other</td>
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<td>Other</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

## My List of Medical Supplies and Equipment

Medical Supplies and Equipment Recommendations for my Discharge

(A list of potential vendors is available upon request)

<table>
<thead>
<tr>
<th>What I Need</th>
<th>Where can I get it</th>
<th>Do I know how to use it safely?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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## My Questions

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Development

My Safety at Home

My Safe Return Home

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>If No, Who can I ask to find out</th>
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<tbody>
<tr>
<td>I know who to call</td>
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<tr>
<td>if I don't feel well?</td>
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<tr>
<td>I know who to call</td>
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<td>if I need more help?</td>
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<td>I know how to prevent</td>
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<td>a fall at home?</td>
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Help a loved one sustain their independence.

Bruyère Helpline

613-562-6368

Subsidies available for low-income households.

Bruyère Helpline is a not-for-profit outreach service that allows a senior or with a person with a disability living independently in the community to call for help by simply pressing a button on a small wireless pendant or bracelet.

Help calls are answered by specially-trained professionals at a bilingual 24-hour emergency response centre.

Arrange for your Bruyère Helpline Now!

Contact your Doctor if you have any new symptoms or if your symptoms get worse.

<table>
<thead>
<tr>
<th>I might feel</th>
<th>What to do</th>
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If you are not sure what to do Call your Doctor.

<table>
<thead>
<tr>
<th>I have a family doctor</th>
<th>Yes</th>
<th>No</th>
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Health Care Connect

If no, call Health Care Connect

1-800-445-1822

www.ontario.ca/healthcareconnect

My Family Doctor's name:

Phone:

Email:
My Follow up Appointments and Tests

Go See:
for: ____________________________ on: ____________________________
Location: ____________________________ Phone #: ____________________________
Questions: ____________________________________________

My Community Care Access Centre (CCAC)
Plan for Home

My Care Coordinator is: ____________________________
Phone #: ____________________________

[Checkboxes for understanding CCAC plan]
Yes No

I have received and understand my CCAC plan for home.
I know who will be coming to help me at home.
I know when they will be coming to help me at home.
I know what they will be helping me with at home.

The CCAC Phone Number is: 310-2222 (no area code required)
or 1-800-538-0520 (toll free)

My CCAC Questions

__________________________________________
__________________________________________
__________________________________________

[Blank lines for additional questions]
My Path to Home Resources
For some great community resources that can help you stay active, healthy and supported in the community:

Step 1: Open your internet browser
Step 2: In your internet browser search box, type www.bruyere.org

Step 3: In the Bruyère homepage search box, type your path to home web resources

Step 4: Click the link (in red) indicated by the black arrow

Results

No search results for your search terms.

Pages

Step 5: Click the links on the side of the webpage to access useful resources to help you get back home safely

Patient & Resident Resources

Click one of the red links to access a resource
### Path to Home passport

**Month:**

<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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<th>Saturday</th>
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### Appointments I have to go to

**Go see:**

- **for:**
  - **on:**

**Location:**

- **Go see:**
  - **for:**
  - **on:**

**Location:**

---

**Where to go for more information:**

- My Community Pharmacy
- My Family Doctor
- My Caregiver
- Important Number
  - 1.
  - 2.
  - 3.

---

**My CCAC Care provider**

- **Name:**
- **My CCAC Care Coordinator**

---

For sudden changes in your health:

**CALL 911** 613-244-7272

For questions about your health:

**Telehealth Ontario**

1-866-797-0000
TTY: 1-866-797-0007

bruayera.org

Bruyère
Step 9: Get approval

- Working group
- Debbie Gravelle (project lead)
Development

Step 10: Produce the material

- PTHP
- Fridge Magnet
- Pen
- Tote (bag)
Step 11: Distribute the material

- Team members (on units where the PTHP was going to be rolled out) were **briefed on the purpose/use of the tool by team lead**

  - The fact that the passport is a workbook that is patient led was attractive to health care team members who are concerned about workload

  - **RSW** responsible for introducing patients to PTHP **early on in patient hospital stay**. RSW would introduce PTHP **one week** after admission.

  - PTHP rolled out to patients and caregivers in our **rehabilitation population** in our **Home First Program**
What is Home First?

- Home First is about **making every effort to support patients to go home after a hospital stay** rather than planning for future care options, such as Long Term Care placement, from hospital.

- By applying the Home First philosophy in our hospital, patients’ care needs will be better identified and supported so they can go home to make important decisions about their future.

- It’s an approach that helps hospital patients to continue their recovery at home with community supports as needed.
Timeline of rollout:

- **August 2016**: Rolled out at Saint Vincent Hospital 4N Low Intensity Restorative Program
- **February 2017**: Roll out and Evaluation Study with UHN begins at Elisabeth Bruyère Hospital on Geriatric Rehabilitation Level 6
- **May 2017**: Roll out to Saint Vincent Hospital 3S Restorative Wound Program
Step 12: Evaluate the material
N = 280 Patients/Caregivers

- Inclusion Criteria:
  - CHF
  - COPD
  - Stroke
  - Pneumonia
  - Hip Fracture
  - Knee or Hip Replacement
N = 280 Patients/Caregivers

- **Mixed Method Trial:**
  - EBH Level 6 – Usual Care + PTHP
  - EBH Level 3 – Usual Care

- **Follow up post discharge:**
  - 1 week – Primary Outcomes
  - 1 month – Secondary Outcomes
PODS Evaluation Study

Patients (or caregiver) interviewed at 1 week post-discharge for primary outcomes:

CIHI Patient Experience In-Patient Survey
PODS Evaluation Study

Patients (or caregiver) interviewed at 1 month post-discharge for secondary outcomes:

- Self-reported adherence to discharge instructions
- Composite of unscheduled utilization of health services
PODS Evaluation Study

Phase 1 – Education
- Education (background Information + expectations)

Phase 2 – Begin Study
- Collect Information from patients (eligible + consent)

Phase 3 – End Study
- Target numbers met = 140 patients Level 3 and 6

Phase 4 – Roll out PTHP at EBH Rehab Level 3
- Provide education and support to roll out

Phase 5 – Evaluation and Analysis
- UHN (Open Lab)
PODS Evaluation Study

CIHI Patient Experience In-Patient Survey on Transitions of Care (primary outcome)

- **Standardized** questionnaire
- Enables patients to provide feedback about the **quality of care** they received during their most recent stay in a Canadian hospital
- Aid hospitals in their **assessments of patient experiences**
- Provide a platform for **national comparisons and benchmarking** for the measurement of patient experience
PODS Evaluation Study

CIHI Patient Experience In-Patient Survey on Transitions of Care (primary outcome)

- During this hospital stay, did doctors, nurses or other hospital staff talk with you about **whether you would have the help you needed** when you left the hospital?

- During this hospital stay, did you **get information in writing** about what symptoms or health problems to look out for after you left the hospital?

- Before you left the hospital, did you have a **clear understanding about all of your prescribed medications**, including those you were taking before your hospital stay?
Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?

When you left the hospital, did you have a better understanding of your condition than when you entered?

When you left the hospital, did you have a clear understanding about your follow-up appointments and investigations?
Secondary Outcomes:

- Self-reported adherence to all medications
- Self-reported adherence to diet restrictions
- Self-reported adherence to activity restrictions
- Self-reported adherence to scheduled visits measured at 30 days following discharge, as well as a binary composite outcome of any unscheduled visits to primary care physician, emergency room, readmission to hospital or death at 30 days and 3 months following discharge.
PODS Evaluation Study

Phase 1 – Education
- Education (background Information + expectations)

Phase 2 – Begin Study
- Collect Information from patients (eligible + consent)

Phase 3 – End Study
- Target numbers met = 140 patients Level 3 and 6

Phase 4 – Roll out PTHP at EBH Rehab Level 3
- Provide education and support to roll out

Phase 5 – Evaluation and Analysis
- UHN (Open Lab)
It’s been **a year since full implementation** at our sites

What have we learned so far?

- Patients and caregivers are **not always comfortable in taking the lead** and need positive reinforcement by the health care team to actively facilitate the completion of the PTHP.

- The **care team needs reassurances** that the book does not add extra work but when patients and caregivers are able to have their questions answered they have an improved discharge outcome.
Results from Interviews with Patients and Caregivers:

The Path to Home Passport **helped me know what I needed to** and ask the questions I needed to ask before I was discharged.
Results from Interviews with Patients and Caregivers:

The Passport kept me organized and helped me to understand the process of getting ready to go home.
Implementation

Results from Interviews with Patients and Caregivers:

The **magnet** is helpful to make sure **all my information is in one place**
Implementation

Results from Interviews with Patients and Caregivers:

The Passport is easy to read and understand.
Implementation

Results from Interviews with Patients and Caregivers:

I feel like I am prepared to go HOME
Future Steps

- **APP**
  - iOS + Android
  - **$50,000 SPARK Grant** from the Centre for Aging + Brain Health Innovation to develop a helpful and easy to use App
  - Have formed working group and have just started preliminary meetings
  - For **caregivers** primarily
Future Steps

○ APP

Development of a “Path to Home” mobile application for the geriatric rehabilitation program at Bruyère Continuing Care: A study protocol

Authors:
Chantal Backman\textsuperscript{1,2}, Anne Harley\textsuperscript{3}, Patrick Hurteau\textsuperscript{3}, Craig Kuziemsky\textsuperscript{4}, Jay Mercer\textsuperscript{3}, Judith Minorgan\textsuperscript{3}, Anne Monahan\textsuperscript{3}, Helen Niezgoda\textsuperscript{2}, Liam Peyton\textsuperscript{5}, Sandra Schmidt\textsuperscript{3}, Chantal Séguin\textsuperscript{3}, Harvinder Singh\textsuperscript{3}, Jessica Singh\textsuperscript{3}, Marion Whiting\textsuperscript{3}, Ron Whiting\textsuperscript{3}, Debbie Gravelle\textsuperscript{3}

\textsuperscript{1}School of Nursing, Faculty of Health Sciences, University of Ottawa, Ottawa, Canada
\textsuperscript{2}Bruyère Research Institute, Ottawa, Canada
\textsuperscript{3}Bruyère Continuing Care, Ottawa Canada
\textsuperscript{4}Telfer School of Management, University of Ottawa, Ottawa, Canada
\textsuperscript{5}Faculty of Engineering, University of Ottawa, Ottawa, Canada

\[\text{UNDER CONSTRUCTION}\]
No studies, to our knowledge, have looked at specifically using technology to integrate the hospital to home transition processes to support patients in meeting their personalized needs and in providing them with better integration of care between health care sectors.

We hypothesize that a technology-supported person- and family-centered care transition could empower geriatric rehabilitation patients, engage them in shared decision-making and ultimately help them to safely manage their personalized needs during care transitions from hospital to home.
Future Steps

- APP

  - The purpose (of this study) is to **design, and test the feasibility, usability, and acceptability** of a novel “Path to Home” mobile app designed to manage the personalized needs of geriatric rehabilitation patients during their transition from hospital to home.

  - Collaborate with **NexJ Health**, a provider of cloud-based population health management solutions (https://www.nexjhealth.com), to **design and configure** a personalized care transition “Path to Home” mobile app.
Future Steps

- Pictograms

  - All of our information in the PTHP is written (in words), **is there any value in the use of pictograms?**

  - Aphasia institute – **purchased validated pictograms**
    - Implementation
    - Evaluation
Future Steps

- **Revisions** are underway to co-design a Path to Home Passport for Stroke Rehabilitation and for Frail Older Senior

  - Emphasis on **checklists**
  - More space to add own information
  - Slightly **fewer pages**
  - Focus on fall prevention and medication management best practices
  - Not finalized (**draft**)
  - **Should this be the new “regular” PTHP?**
Bruyère Path to Home Passport for Seniors

The Path to Home Passport was created together with patients, families, and your care team, the Champlain LHIN Home and Community Care and the Bruyère Research Institute. We worked together to make sure that you have the right information to help you decide what you need to prepare you to go home safely. Before you go home, you will receive your Path to Home Passport. We hope you and your caregiver will find it a useful tool to help you start thinking about your return to home.

We ask you to begin to use the checklists to highlight what is most important to you. As you work through your Passport, the checklists will help you to know what questions to ask the members of your care team.

Research shows that a well-planned return home can decrease your chance of going back to the hospital and help with your recovery. We also want to make sure that you know how to take your medicines, and understand your other needs when you return home.

For more information, please talk to the members of your health care team and visit our Path to Home e-Resources Website at http://www.bruyere.org/en/path-home-resources

Thank you,

Debbie Gravelle RN BScN MEd
Senior VP clinical programs,
Chief Nurse Executive and
Chief of Allied Health and Pharmacy
Future Steps

Preparing to go home

Name:

- [ ] Saint-Vincent Hospital
  60 Cambridge Street North
  Ottawa, Ontario K1R 7A5
- [ ] Elisabeth Bruyère Hospital
  43 Bruyère Street
  Ottawa, Ontario K1N 5C8

Room Number:

Arrived at the Hospital: ___/___/___

Leaving the hospital: ___/___/___

Reason for Hospital Stay:

When I leave hospital I will go:

- [ ] Home with my spouse/family/friends
- [ ] Retirement Home
- [ ] Home by myself
- [ ] Not sure at this time

Where do I go to have Questions Answered?
For all general questions about your care ... Please ask your assigned nurse for help.

What would you like to accomplish while in hospital?

My Goals:

In preparing to return home, check what is most important to you.
Use this list to share what is most important to you with your care team members.

Preparing to Go Home

- Getting and using equipment (walker, commode, wheelchair)
- Changes to my home (ramp, stair lift, bath chair, furniture)
- Medical supplies

Daily Care Needs

- Understanding of daily care needs (patient/caregiver)
- Memory aids (when to get up, what meals to eat, activities to do)
- Managing medications
- Getting around
- Daily care routine (bathing, eating, personal hygiene, dressing, lower body, getting to and from the toilet, getting from one place to another and transferring safely)
Future Steps

Daily Care Needs
- Keeping Healthy
- Staying Active/Home Exercises
- Changes to my Diet
- Changes to my Activity Level

Path to Home
- When to call the doctor
- Safety at Home (Preventing Falls)
- Home Care Help
- Community Resources I can use
- Helpful resources (grocery delivery)
- Follow up Appointments and Tests
- Finances
- My Caregiver’s Health

Other things on my mind...

What are you most concerned or worried about in returning home? Be specific.

Care needs when home

Daily Care Needs
Getting Ready
Please Check
- My Caregiver understands my needs and knows what to do
- Memory Aids (when to get up, have meals, clothes to wear, activities to do)

Managing Medications
5 Questions to Ask About Your Medications when you see your doctor, nurse, or pharmacist.
Before you leave hospital... Be sure you know:
Please Check
1. Changes – Have medications been added, stopped or changed, and why?
2. Continue – What Medications do I need to keep taking, and why?
3. Proper Use – How do I take my medications, and for how long?
4. Monitor – How will I know if my medications is working and what side effects do I look for?
5. Follow-Up – Do I need any tests and when do I book my next visit?

(See www.SafeMedicationUse.ca for more Information)
# Future Steps

## Daily Care

<table>
<thead>
<tr>
<th>Activity</th>
<th>I can do it myself</th>
<th>I need a little bit of help</th>
<th>I need a lot of help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing my lower body</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting to and from the toilet</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Questions

- _____________________________
- _____________________________
- _____________________________
- _____________________________
- _____________________________

## Keeping Healthy

<table>
<thead>
<tr>
<th>Activity</th>
<th>Not Applicable</th>
<th>I can do it myself</th>
<th>I need a little bit of help</th>
<th>I need a lot of help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Sugar Monitoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin Injections</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Blood Pressure Monitoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain Monitoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

## Questions

- _____________________________
- _____________________________
- _____________________________
- _____________________________
- _____________________________

## Healthy Living

<table>
<thead>
<tr>
<th>Activity</th>
<th>I can do it myself</th>
<th>I need a little bit of help</th>
<th>I need a lot of help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buying, preparing and eating the right foods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staying active</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing home exercises as recommended</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Questions

- _____________________________
- _____________________________
- _____________________________
- _____________________________
- _____________________________
Future Steps

Path to Home Resources

Equipment and Medical Supplies

<table>
<thead>
<tr>
<th>What I need</th>
<th>Where to get it</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Questions

<table>
<thead>
<tr>
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</tr>
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<tbody>
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</tbody>
</table>

When to Call the Doctor

Pay attention to the following health concerns... who is going to fill this part?

If I feel __________________________ Do this __________________
If I feel __________________________ Do this __________________
If I feel __________________________ Do this __________________

Questions

<table>
<thead>
<tr>
<th>Question</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Safety at Home – Reaching out

Not feeling well... call
The Doctor/Clinic __________________________ Number __________________________

If more help is needed... call
The Doctor/Clinic __________________________ Number __________________________

The Fall Prevention Checklist

<table>
<thead>
<tr>
<th>Item</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>I steady myself by holding on to furniture when walking at home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This is also a sign of poor balance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am worried about falling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who are worried about falling are more likely to fall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I need to push with my hands to stand up from a chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This is a sign of weak leg muscles a major reason for falling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have some trouble stepping up on a curb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This is a sign for weak leg muscles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often have to run to the toilet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rushing to the bathroom, especially at night, increases your chance of falling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have lost some feeling in my feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness in your feet can cause stumbles and my lead to falls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take medicine that sometimes makes me feel light headed or more tired than usual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Side effects from medications sometimes increase your chance of falling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take medicine that helps me sleep or to improve my mood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>These medications can sometimes increase your chance of falling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often feel sad or depressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptoms such as not feeling well or feeling slowed down can be linked to falls</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total: __________________________

Add up the number of points for each “YES” answer. If you score 4 points or more, you may be at risk of falling. Discuss this checklist with your Care Team.
Future Steps

We can help you sustain your independence.

Bruyère Helpline 613-562-6368
Subsidies available for low-income households.

Bruyère Helpline is a not-for-profit outreach service that allows you to live independently in the community and to call for help by simply pressing a button on a small wireless pendant or bracelet. Help calls are answered by specially-trained professionals at a bilingual 24-hour emergency response centre.

Arrange for your Bruyère Helpline now!

Important Phone Numbers:
My Primary Caregiver(s) ________________________________
Number ________________________________
My Primary Caregiver(s) ________________________________
Number ________________________________
My Community Pharmacy ________________________________
Number ________________________________
My Family Doctor ________________________________
Number ________________________________
Home and Community Care ________________________________
Number ________________________________

Follow up Appointments and Tests
☐ Yes  ☐ No  If yes, Please complete the following information.

Appointment 1
Appointment with: ________________________________
For: ________________________________ on: ________________________________
Location: ________________________________
Phone No.: ________________________________
Questions: ________________________________

Appointment 2
Appointment with: ________________________________
For: ________________________________ on: ________________________________
Location: ________________________________
Phone No.: ________________________________
Questions: ________________________________

Appointment 3
Appointment with: ________________________________
For: ________________________________ on: ________________________________
Location: ________________________________
Phone No.: ________________________________
Questions: ________________________________
Future Steps

Final Checklist

Preparing to Go Home
- The home destination is ready for me
- Equipment, Medical Supplies are in place

Daily
- I know about the Care Routine (what and how the care will be done)
- I know how what needs to be done to get ready (go to the toilet, brush my teeth, wash my hand and face, comb my hair, have a bath or shower)
- I know how I will get around when I am home (transfer, use stairs, walk, stay active, get to and from my appointments)
- I know how to take my medications (the 5 Questions)
- I know memory aids I can use
- I know what I need to know to keep healthy (self-monitoring my health)
- I know what I need to do for healthy living (food, exercise, staying active)
- I know the changes in my health to watch for and when I need to call my doctor

Path to Home - Keeping Safe at Home
- I know who to call if I am not feeling well or need more help
- I know how to prevent falls in my home (Final Checklist)
- I know about my follow-up appointments (who, what, where, when, and how I will get there)

Home and Community Care Plan
- I have met with the Home and Community Care Coordinator
- I know my Home care plan (who is coming, when and what they will help me with)
- I know how to access Community Resources that will help me live at home safely and successfully

Congratulations... Your Passport is Complete!
Your Bruyère Care Team
Value of PTHP

**Patient/Caregiver**
- Prompts questions from patient and caregiver
- Provides written discharge instructions to increase understanding
- Improves patient hospital experience/satisfaction
- Reduces patient anxiety at discharge
- Improves health literacy

**Providers**
- Standardizes discharge instructions
- Standardizes hospital discharge procedures
- Promotes dialogue between patient and healthcare team

**Health Care System**
- Ensures use of evidence based practices
- Ensures continuity of care between different levels of healthcare system
- Reduces readmissions and need for unscheduled medical care
Partnerships

Canadian Foundation for Healthcare Improvement

Fondation canadienne pour l’amélioration des services de santé

UHN Toronto General & Western Hospital Foundation

OPENLAB

Proud Member UHN

CCAC

Centre d'accès aux soins communautaires

SOINS CONTINU Bruyère

INSTITUT DE RECHERCHE Bruyère RESEARCH INSTITUTE

Afflié à l'Université d'Ottawa
Affliated with the University of Ottawa

PATH TO HOME

PASSPORT

Bruyère
Partnerships
Questions

Email: hsingh@bruyere.org