CFHI's *Bridge-to-Home* (BTH) Spread Collaborative - Logic Model (v.10 Feb 5, 2019)

INPUTS

Improvement Teams: Inter-disciplinary teams of providers, patients & caregivers, measurement and evaluation leads

Other human resources: Patient & caregiver partners; providers and leaders from hospitals, home and community organizations; inter-professional teams; IT support

Collaborative resources: seed funding; Desktop technology; QI and evaluation content experts; PFE and transitions of care advisors, coaches, faculty; CFHI staff

The Innovation: Patient-oriented care transitions bundle (an evidence-based improvement worth spreading)

CFHI's Guiding Principles for Patient & Family Engagement

ACTIVITIES

Macro-level: CFHI's BTH Spread Collaborative

- Engage patient and caregiver partners to guide CFHI in all phases of BTH collaborative
- Support teams to adapt, implement and measure the care transitions bundle:
  - ➔ Enhance capacity through training (webinars, workshops) and supports for learning (Desktop)
  - ➔ Provide coaching from experts (researchers, patient leaders, practitioners and healthcare leaders) on PFE, BTH and QI
  - ➔ Create networking opportunities to learn from each other about "what works"
  - ➔ Provide CQI feedback regularly
  - ➔ Provide tools to monitor process indicators for PFE
- Support teams to meaningfully engage with patients/caregivers in QI
- Support teams to spread* the care transitions bundle:
  - ➔ Assess if teams are ready to spread beyond their 'pilot'
  - ➔ Supports teams to integrate and spread the bundle beyond the pilot site

Meso-level: BTH Improvement Teams

- Participate in training, coaching and networking opportunities
- Meaningfully partner with patients and caregivers as team members
- Build partnerships within local BTH network teams
- Engage providers within their organizations to build buy-in for BTH
- Adapt (as needed) and implement the care transitions bundle
- Measure, monitor and report on progress
- Share lessons learned with other BTH teams
- Spread the innovation beyond the initial pilot site

Micro-level: Direct Care Teams in BTH organizations

- Participate in training
- Engage patients, families, caregivers
- Implement the innovation bundle

OUTPUTS

OUTPUTS

- # and type of capacity building events (training, coaching, networking, feedback) offered
- # of patients and caregivers involved and at what level of the IAP2 continuum
- # of teams that spread BTH beyond the original implementation site
- # of target organizations reached in spread of BTH

- # and type of capacity building events attended
- # of patients and caregivers involved and at what level of the IAP2 continuum
- # and type of teams/units that implement care transitions bundle
- # and type of adaptations made to the transitions bundle
- # of teams that spread BTH beyond the original implementation site
- # of target organizations reached in spread of BTH

- # and type of training events attended
- # of patients and caregivers who receive the transitions bundle

OUTCOMES

Short-term outcomes

- Increased knowledge and skills of: QI methodology; the patient-oriented care transitions bundle; meaningful patient & caregiver engagement
- Increased understanding of "ideal care transition" from hospital to home/community care, from perspective of patients, caregivers & providers
- Increased high-quality opportunities for patients & providers to work together on BTH

Intermediate Outcomes

- Improved provider experiences and satisfaction in delivery of transitions of care, incl. partnership satisfaction
- Improved patient experiences of transitions from hospital to home/community
- Improved caregiver experiences of transitions from hospital to home/community
- Improved communication between providers and patients/caregivers in discharge planning

Long-term Outcomes

- Improved confidence of patients and caregivers to manage their care as they transition home
- Increased integration of patient & caregivers in discharge planning
- Increased partnerships with patients & caregivers in other QI initiatives
- Reduced avoidable hospital readmissions

BTH Assumptions:

- Meaningful engagement of patients and families is a critical factor for care transitions to be patient-oriented. Care is delivered “with” them, not “to” them.
- Patient engagement accelerates improvement and health outcomes
- Organizations mature and develop into “engagement capable environments”. It takes time to build PFE capacity.
- CFHI’s team-based collaborative model, using an “All teach; All learn” approach to building capacity, is an evidence-based approach to spread health care improvements
- Improvement Project teams have assembled the right people, with the right skills and time to see the BTH project through to completion. Team composition may evolve as projects progress.
- Factors beyond the collaborative (i.e., organizational context, system readiness, individuals involved, etc.) may also influence the intended outcomes
- While the patient-oriented transitions bundle has some core components, we expect it will be adapted to fit local context.
- CFHI ‘walks the talk’ of Patient & Family Engagement (PFE) by applying and reflecting on its own *Guiding Principles for PFE*

**Spread: The transfer of a best practice from one site to another (from ‘best’ to ‘common’ practice). Spread goes beyond diffusion to actual implementation. (CFHI working definition – under revision)*