SONDER HEALTH PLAN TRANSITION OF CARE PROTOCOL

Sonder Health Plan is committed to making all care transitions a smooth, seamless transition and has developed this Care Transition Protocol in conjunction with recommendations from the World Health Organization (WHO). Our goal is to improve member health outcomes and reduce healthcare costs.

Identified problems associated with transition include:

- increase in mortality
- increase in morbidity (temporary or permanent injury or disability)
- increase in adverse events n delays in receiving appropriate treatment and community support
- additional primary care or emergency department visits
- additional or duplicated tests or tests lost to follow-up
- preventable readmissions to hospital
- emotional and physical pain and suffering for service users, caregivers and families
- patient and provider dissatisfaction with care coordination

Recommended Interventions include:

- standardizing documentation and agreeing on which information should be included in referral and discharge documents
- discharge planning with agreed criteria and protocols
- improving the quality and timeliness of discharge documentation
- implementing effective medication reconciliation practices
- conducting timely and appropriate member follow-ups, including telephone calls and/or home visits
- improving the effectiveness and timeliness of clinical handovers between clinicians
- establishing a 24 hour nurse line for members access
- assigning care coordinators or case managers to members with complex needs
- increasing the involvement of primary care physicians
- educating and supporting patients, families and caregivers

To reduce risk, Sonder Health Plan is committed to:

- complying with nationally agreed guidelines
- agreeing on terminology used between health care providers and care settings
- standardizing information transfers (e.g. discharge summaries and their delivery, irrespective of where they were generated or who is to receive them)
- establishing tracking systems for diagnostic and follow-up tests, referrals and appointments
- using simple checklists
- robust discharge planning

Sonder is committed to prioritizing for effective transitions of care by including the following with all care transitions:

1. Sharing tools and developing governance arrangements
    a. building shared approaches to governance across organizations and sectors; networked governance may support safer transitions of care;

   b. using electronic health records with interoperability across sectors and organizations so that information can be transferred between points of care without having to rely solely upon oral communication between health care providers
   c. standardizing processes related to appointments, medical records, test results, information flow and communication
   d. using simple checklists to ensure key tasks are performed in a standardized manner, including follow-up
   e. implementing tracking systems for diagnostic tests, referrals and appointments.
2. Using a systems approach
   a. combining evidence-based interventions to support safer and smoother transitions. No single intervention has been consistently found to address all the issues and thus solutions require a systems approach. This may include three aspects for all members: (i) involving patients and caregivers as part of the team; (ii) timely transfer of accurate clinical and social information between settings; (iii) medication reconciliation. Some members identified as being at higher risk may require additional measures tailored to their individual clinical and social needs
   b. considering a range of evidence-based initiatives, such as discharge planning, medication reconciliation, timely patient follow-up, timely clinical handovers, patient and caregiver support and education strategies.
3. Identifying those most at risk of safety incidents
   a. using tools to identify transitions at high risk of safety incidents
   b. undertaking research to inform improvements in transitions of care, particularly for the elderly, those with complex conditions, and members with low socioeconomic status.
4. Focusing on enhancing relationships and communication
   a. showcasing strategies to improve communication between patients and health care providers, and among organizations
   b. providing checklists and written instructions about the transition for patients, family members and caregivers
   c. using agreed standardized terminology between primary and secondary care.