Appendix A: Glossary of Terms

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Best possible medication history (BPMH): A best possible medication history (BPMH) is a medication history obtained by a health provider using: (1) a systematic process of interviewing the person/and or their support network; and (2) a review of at least one other reliable source of information to obtain and verify all regular medication use. The BPMH includes the drug name, dose, route and frequency of all medications (prescribed and non-prescribed) that a person is currently taking. The BPMH is a snapshot of the person's actual medication use, which may be different from what is listed in their records (115).

Best practice guidelines (BPG): "Best practice guidelines are systematically developed, evidence-based documents that include recommendations for nurses and the interprofessional team, educators, leaders and policy-makers, persons and their families on specific clinical and healthy work environment topics. BPGs promote consistency and excellence in clinical care, health policies and health education, ultimately leading to optimal health outcomes for people and communities and the health system" (116).

Best Practice Spotlight Organization® Ontario Health Team (BPSO OHT): Ontario Health Teams (OHT) are groups of providers and organizations that are accountable for delivering a full and coordinated continuum of care to a attributed population in Ontario, Canada (9). The Best Practice Spotlight Organization® (BPSO) model for OHTs offers a tailored program to scale up and spread RNAO BPGs within integrated systems of care. The BPSO OHT model helps OHTs advance all four elements of the Quadruple Aim and the United Nations Sustainable Development Goals (SDG) by addressing population health, supporting underserviced populations and promoting health equity. BPSO OHTs are actively supported by RNAO to systematically implement evidence-based BPGs by mobilizing teams towards their collective goals, and evaluating outcomes. The BPSO OHT program is nested within the OHT, and program deliverables are designed to advance OHT goals.

Caregiver: "A family member, friend or person of choice who gives unpaid care to someone who has care needs due to a disability, a physical, neurological or mental condition, a chronic illness, frailty or age" (117). Caregivers are often key members of a person's support network.

Continuity of care: Continuity of care is about the quality of the transition in care. It is the extent to which care is well coordinated and connected as persons move between settings and through the health system (118).

Culturally safe care: People providing culturally safe care are attempting to provide respectful engagement that recognizes and aims to address power imbalances inherent across the health system (119). Culturally safe care aims to create and sustain an environment that is free of racism and discrimination, where people feel safe when receiving health care. Indigenous people, families and communities should be able to share their perspectives, ask questions and have their beliefs, behaviours and values be respected by health and social service providers (119).

Discharge summary: A summary of what happened during a person's medical stay in a hospital, rehabilitation facilitation or other health-care setting (120). It often includes the person's medical diagnosis, test results and pending test results, changes made to treatments or medications (including the reasons why), and follow-up needs. The discharge summary is a way of communicating a person's transition plan to providers in the setting to which the person is transitioning (121). Discharge summaries written in plain language can also be created for persons and their support network in order to provide them with important information, such as changes to medications and follow-up appointments.

Downgrade: In GRADE, when limitations in the individual studies potentially bias the results, the certainty of evidence will decrease (122). For example, a body of quantitative evidence for one priority outcome may begin with high certainty, but due to serious limitations in one or more of the five GRADE criteria, it will be rated down by one or two levels (122).

Education statements: Organizational approaches to the delivery of education in health service organizations and academic institutions to support evidence-based practice. Education statements are based on an analysis of educational recommendations across several BPGs on diverse clinical topics and populations. Education statements can be applicable to all clinical BPGs and can be contextually adapted within health service organizations and academic institutions to support implementation of clinical recommendations.

Evidence-based practice: The integration of research evidence with clinical expertise and patient values. It unifies research evidence with clinical expertise and encourages the inclusion of patient preferences (123).

Evidence-to-Decision (EtD) frameworks: A table that helps expert panels make decisions when moving from evidence to recommendations. The purpose of the Evidence-to-Decision framework (EtD) is to summarize the research evidence, outline important factors that can determine the recommendation, inform panel members about the benefits and harms of each intervention considered, and increase transparency about the decision-making process in the development of recommendations (19).

Electronic health record: An electronic health record is a secure, private, lifetime digital record of a person's health and care history that gives authorized health and social service providers real-time access to relevant medical information (124). Access to shared electronic health records refers to authorized health and social service providers in different organizations and sectors having joint access to a person's electronic health record in order to streamline communication and coordinate care.

Follow-up visit with a health or social service provider: Refers to attending an outpatient follow-up appointment to assess a person's health status following a transition in care.

Good practice statement: Good practice statements are directed primarily to nurses and the interprofessional teams who provide care to persons and their support network across the continuum of care, including (but not limited to): primary care; home and community care; acute care; and LTC.

Good practice statements are actionable statements that should be done in practice (16). These statements are believed to be so beneficial that summarizing the evidence would be a poor use of the expert panel's time and resources (16). Moreover, researchers may no longer be conducting studies on the topic, or the alternative to the action may be unethical or studying them may go against human rights (16,17). Given the high level of certainty that the benefits derived from good practice statement outweigh the harms, they are not based on a systematic review of the evidence. They also do not receive a rating of the certainty in their evidence or a strength (i.e., a rating of conditional or strong, which is further discussed below) (18). This does not diminish certainty in the evidence: while they may be supported by indirect evidence, there is a well-documented clear and explicit rationale connecting the indirect evidence to the statement (16). As such, good practice statements should be interpreted as strong recommendations, as there is an underlying assumption that there is high certainty in the benefits of implementing the action (16).

Grading of Recommendations Assessment, Development and Evaluation (GRADE): The Grading of Recommendations Assessment, Development and Evaluation (GRADE) is a methodological approach to assess the certainty of a body of evidence in a consistent and transparent way, and to develop recommendations in a systematic way. The body of evidence across identified important and/or critical outcomes is evaluated based on the risk of bias, consistency of results, relevance of studies, precision of estimates, publication bias, large effect, dose-response and opposing confounding (19).

When using GRADE, five components contribute to the assessment of confidence in the evidence for each outcome. These components are as follows:

1. Risk of bias, which focuses on flaws in the design of a study or problems in its execution.

2. Inconsistency, which looks at a body of evidence and assesses whether the results point in the same direction or if they are different.

3. Imprecision, which refers to the accuracy of results based on the number of participants and/or events included, and the width of the confidence intervals across a body of evidence.

4. Indirectness, whereby each primary study that supports an outcome is assessed and a decision is made regarding the applicability of the findings to the population, intervention and outcome outlined in the research question.

5. Publication bias, where a decision is made about whether the body of published literature for an outcome potentially includes only positive or statistically significant results (19).

Health and social service organizations: In this BPG, health and social service organizations refer to any settings in which a person, together with their support network, receives care or services during a transition in care.

Health service organizations are organizations delivering health-care services to defined communities or populations. This includes, but is not limited to, family health teams, home care organizations and hospitals.

Social service organizations are organizations that assist persons with social issues, including (but not limited to) housing, domestic violence and substance use.

Health and social service providers: Refers to both regulated health and social service providers (e.g., nurses, physicians, pharmacists, social workers, occupational therapists and paramedics) and unregulated health and social service providers (e.g., personal support workers, peer workers with lived experience) who are part of the interprofessional team.

Regulated health and social service providers: The *Regulated Health Professions Act*, *1991* (RHPA) governs the regulation of health professions in Ontario in order to protect the public. It outlines the scope of practice and the profession-specific controlled or authorized acts that each regulated professional is authorized to perform when providing health care and services (10). The regulations for social workers and social service professionals are outlined in the *Social Work and Social Service Work Act*, *1998* (11). In this BPG, nurses, physicians, occupational therapists and pharmacists are examples of regulated health providers, and social workers are an example of a regulated social service provider.

Unregulated health and social service providers: This provider fulfills a variety of roles in areas that are not subject to the RHPA. They are accountable to their employers but not to an external regulating professional body (for example, the College of Nurses of Ontario). Unregulated health and social service providers only have the authority to perform a controlled act as set out in the RHPA if the procedure falls under one of the exemptions set out in the Act (12).

Health literacy: The ability of a person to obtain and translate knowledge and information in order to maintain and improve health in a way that is appropriate to the individual and system contexts. Health literacy covers three broad elements: (1) knowledge of health, health care and health systems; (2) processing and using information in various formats in relation to health and health care; and (3) ability to maintain health through self-management and working in partnership with health providers (125).

Home: A person's usual place of residence. This may be a personal residence, assisted-living facility, LTC home, hospice or shelter (25).

Implementation science: Defined as "the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services and care" (126).

Indigenous: Introduced and used in a global context following the international efforts of Aboriginal peoples to achieve a greater presence in the United Nations (UN). The UN broadly defines Indigenous persons as peoples of long settlement and connection to specific lands who practice unique traditions and retain social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they reside (127). Under the UN definition, Indigenous is generally understood to include: self-identification at the individual level and acceptance by an Indigenous community as a member; historical continuity with pre-colonial or pre-settler societies; strong links to territories and surrounding natural resources; distinct social, economic or political systems; and distinct language, culture and beliefs. Indigenous peoples form non-dominant groups within society and resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities (127).

The Canadian Constitution recognizes three groups of Indigenous peoples: First Nations, Inuit and Métis. These are three distinct peoples with unique histories, languages, cultural practices and spiritual beliefs (128).

Integrated systems of care: Services organized across sectors and organizational boundaries so that persons receiving care receive coordinated and comprehensive services at the right time, from the right provider and in the right place (129).

Interprofessional cross-sectoral approach: Refers to a collaborative approach where two or more health or social service providers from different disciplines in different sectors work together in a formal way to ensure persons and their support network experience a safe transition in care. For example, providers in LTC can collaborate with providers in a hospital setting to coordinate care for a person transitioning from LTC to hospital.

Interprofessional team: A team composed of multiple health and social service providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health services to persons within, between and across health and social care settings (13). Key interprofessional team members supporting pediatric and adult persons and their support network during transitions in care include, but are not limited to: nurses, physicians, pharmacists, social workers, occupational therapists and paramedics. It is important to emphasize that persons and their support network who are encountering a transition in care are at the centre of the interprofessional team as active participants.

Medication reconciliation: A formal process in which health providers work together and with persons and their support network to ensure that accurate and comprehensive medication information is communicated consistently during a transition in care. Medication reconciliation requires a systematic and comprehensive review of all the medications a person is taking (known as a "best possible medication history") to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the person (115).

See best possible medication history (BPMH)

Medication-related harm: Harms experienced by a person as a result of exposure to a medication that may be preventable (e.g., due to a medication error) or non-preventable (e.g., an adverse drug reaction) (88).

Navigation support: Refers to individualized and coordinated support provided by health or social service providers to help persons and their support network overcome challenges navigating the health and social care system during transitions in care. In this BPG, navigation support involves regular follow-up by a health or social service provider who attends to a person's individual needs and connects them with the right services and supports. This can include providing persons with the information and resources they need to achieve their goals of care, connecting persons with other health and social service providers, helping reduce barriers that prevent persons from accessing timely care, providing social and emotional support, and improving access to culturally safe care.

Non-randomized study: A quantitative study estimating the effectiveness of an intervention, where people are allocated to different interventions using methods that are not random (130).

Nurse: Refers to registered nurses, licensed practical nurses (referred to as "registered practical nurses" in Ontario), registered psychiatric nurses and nurses in advanced practice roles, such as nurse practitioners and clinical nurse specialists (10).

Outcomes: A dependent variable or the clinical and/or functional status of a patient or population used to assess if an intervention is successful. In GRADE, outcomes are prioritized based on if they: (a) are critical for decision making; (b) important but not critical for decision making; or (c) not important. Use of these outcomes helps make literature searches and systematic reviews more focused (19).

Peer worker with lived experience: A person who has lived through similar experiences to their peers, such as a mental health challenge or illness, and who is trained to support others in their journey by providing practical and emotional support (14). In this BPG, peer workers with lived experience are also referred to as "peer workers." These peer workers are non-regulated.

Person: An individual with whom a health or social service provider has established a therapeutic relationship for the purpose of partnering for health. Replaces the terms "patient," "client," and "resident" that are used across health and social service organizations (131).

Person-centred: An approach to care in which the person is viewed as whole. The process of coming to know the whole person is nurtured through the formation of a therapeutic relationship between the person, those who are significant to them, and health and social service providers. This approach to care involves advocacy, empowerment, mutual respect and an understanding of the person's right to be autonomous, to self-determine and to participate actively in decisions about their health (both illness and wellness) (131).

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Person with lived experience: Members of the community who have first-hand experience and knowledge of the topic of interest as a person, unpaid caregiver or advocate. Persons with lived experience are a diverse group with an array of backgrounds and experiences.

PICO research question: A framework to outline a focused question. It specifies four components:

1. The patient or population that is being studied.
2. The intervention to be investigated.
3. The alternative or comparison intervention.
4. The outcome that is of interest (19).

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram: A diagram that depicts the flow of information through the different phases of a systematic review. It maps out the number of articles identified, included and excluded (132).

Quadruple aim: An internationally-recognized framework for the delivery of health care that is centred around four overarching goals: (1) enhanced experiences for persons receiving care; (2) enhanced experiences for health and social service providers delivering care; (3) improved health outcomes for persons receiving care; and (4) reduced health care costs (45).

Quantitative research: An approach to research that investigates phenomena with tools that produce statistical measurements/numerical data (133).

Randomized controlled trial (RCT): An experiment in which the investigator assigns one or more interventions to participants who are randomly allocated to either the experimental group (receives intervention) and the comparison (conventional treatment) or control group (no intervention or placebo) (130).

Recommendation: A course of action(s) that directly answers a recommendation question (also known as a "PICO research question"). A recommendation is based on a systematic review of the literature and is made in consideration of its: (a) benefits and harms; (b) values and preferences; and (c) health equity. All recommendations are given a strength—either *strong* or *conditional*—through panel consensus.

It is important to note that recommendations should not be viewed as dictates, because recommendations cannot take into account all of the unique features of individual, organizational and clinical circumstances (19).

Recommendation question: A priority research area of practice, policy or education identified by expert panel members that requires evidence to answer. The recommendation question may also aim to answer a topic area around which there is ambiguity or controversy. The recommendation question informs the research question, which guides the systematic review.

Responsive behaviours: Refers to words, actions or gestures presented by persons with dementia or other neurological conditions in response to something frustrating, confusing or important in their social or physical environment (134).

RNAO Clinical Pathways™: RNAO Clinical Pathways are a digitized version of RNAO's BPGs that can be embedded in an electronic hea lth record system to promote evidence-based, person- and family-centred care.

Self-management: This term is often associated with self-care and includes an array of activities that persons undertake to live well with one or more chronic conditions (135).

Social determinants of health: The social determinants of health are "non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems" (136).

Social movement for knowledge uptake and sustainability: Individuals, groups and/or organizations who, as voluntary and intrinsically motivated change agents, mobilize to transform health outcomes (2).

Stakeholder: An individual, group or organization that has a vested interest in the decisions and actions of organizations, and which may attempt to influence decisions and actions (137). Stakeholders include all of the individuals and groups that will be directly or indirectly affected by the change or solution to the problem.

Strength-based approach: Strength-based approaches focus on identifying and supporting the various strengths, motivations, and ways of thinking and behaving, as well as the protective factors—within the person or the environment—that support people in their journeys towards health and well-being (138).

Support network: Individuals identified by a person as being significant in their life. The network can include individuals who are related (biologically, emotionally or legally) and/or those with close bonds (friendships, commitments, shared household and child-rearing responsibilities, and romantic attachment) (15). In this BPG, this term includes family, friends and caregivers providing support during a transition in care.

Sustainable Development Goals (SDG): The Sustainable Development Goals (SDG) were adopted by the United Nations in 2015 as a universal and urgent call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030 (46).

Systematic review: A comprehensive review of the literature that uses clearly formulated questions and systematic and explicit methods to identify, select and critically appraise relevant research. A systematic review collects and analyzes data from the included studies and presents them, sometimes using statistical methods (130).

See meta-analysis

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System navigator: A health or social service provider who provides navigation support during a transition in care over an extended period of time (e.g., for 30 days or six months). In this BPG, the term "system navigator" is used as an umbrella term for all health or social service providers in different roles who provide navigation support in this capacity during a transition in care, including regulated and non-regulated providers (e.g., nurses, social workers, peer workers with lived experience, transition facilitators and patient navigators).

See navigation support

Transition in care: A significant point in the provision of health care during which a person's information and care needs are being transferred between health and social service providers, interprofessional teams and settings (8). A transition in care occurs when a person moves from one setting or sector where care or services are provided to another setting or sector, including (but not limited to): primary care; home and community care; mental health and substance use health settings; acute care; rehabilitation; LTC; correctional facilities; and shelters. Examples include transitions from home to LTC, or hospital to hospice. A transition can also occur within the same organization, such as when a person moves from an intensive care unit to a general ward in a hospital. During their care trajectory, a person may also experience multiple transitions in care, such as a transition from hospital to a rehabilitation facility, and then to home. Although the term "transition in care" is used throughout this BPG, the guideline title reflects how a transition may occur between any settings where care or services are provided.

Transition plan: A plan tailored to a person's needs that is designed to support a transition in care. It is created by the interprofessional team in partnership with the person and their support network, and it describes the coordination of care and support required during and after the transition in care.

Trauma-informed: Trauma-informed approaches are based on an understanding that many people who access health and social services have had experiences of trauma in their lives. Trauma-informed approaches are not focused on providing treatment for trauma; rather, the approach is applied to ensure persons are not further traumatized while accessing care and services. Trauma-informed approaches are based on principles of safety, trustworthiness, collaboration and choice, empowerment, and the building of strengths and skills (139).

Underserved and underserviced populations: Underserved populations can include Indigenous people, people who do not speak either of Canada's official languages, people with alternate sexual orientation, immigrants, refugees, ethnically or racially diverse populations, people with disabilities, those experiencing homelessness, sex workers and people with low incomes. Underserviced means there is an increased likelihood that individuals who belong to a certain population (and people can belong to more than one) may experience difficulties in obtaining needed care, receive less care or a lower standard of care, experience different treatment by health providers or receive treatment that does not adequately meet their needs, or that they will be less satisfied with health services than the general population (140).