



Transforming How We Provide Care to Islanders by Connecting the Continuum

*Provincial Design of Transition
Management in PEI*

January, 2010



ONE ISLAND FUTURE

ONE ISLAND HEALTH SYSTEM

Table of Contents

1.0	BACKGROUND	3
2.0	UNDERSTANDING THE NEED FOR RENEWAL	4
	What are Local Stakeholders Saying?	4
	What are National Trends and Experiences Telling Us?	4
3.0	EXPLAINING THE ABCS OF TRANSITION MANAGEMENT	6
	The ABCs of Transitions – A Starting Point	6
	Understanding Transitions Today – PEI’s Current State	7
	Establishing a Vision and Principles for Transition Management – PEI’s Future	10
	Understanding the Benefits of Effective Transitions – Benefits for Islanders.....	11
4.0	BUILDING NEW “ROADS” TO TRAVEL	12
	Understanding Destinations	12
	New “Roads” – A Conceptual Model for Transitions Across the Continuum	13
	Defining New Roads to Travel – Recommendations	15
	A Healthy System of Care Focused on Keeping Individuals Home – A Self Care Theme	16
	A Focus on Targeted Populations of Need	18
	A Robust Primary Health Care System	19
	Accessible Community Services Based on Need	20
	Coordinated Acute Care	22
	Alignment & Coordination Across Sectors Within the Continuum of Care	25
5.0	ENSURING PEI MOVES FORWARD	26
	Defining a High Level Roadmap for Moving Forward	26
	Managing Obstacles	27
	Leveraging Enablers	27
	Prioritization of Recommendations	28
APPENDIX		29
	Design Team Membership	29
	Survey Summary	31
	Summary of Recommendations	32

1.0 BACKGROUND

The Government of PEI has embarked on an unprecedented transformation of its healthcare system. The vision – **One Island Health Care System** where *care will be delivered through a single, integrated system of care, one grounded in evidence-based decision making and focused on improving health, enhancing access and refocusing the emphasis of the care delivery system on primary health care and services that can appropriately and safely be provided locally. The system is more focused on meeting needs in the most appropriate setting, by the most appropriate provider and in the most cost effective manner.*

Pursuance of the vision has resulted in the development of a comprehensive plan to fully integrate services to ensure Islanders have access to a high quality and sustainable care delivery system. One of the central efforts in this plan is the implementation of a new model of care that is team-based and puts the patient first. Model of care will ensure patients receive the right care within their care settings, while also ensuring the best and most efficient use of PEI's health resources.

To complement the model of care efforts, this design of Transition Management has been launched. While model of care will help to renew how care can be delivered using an inter-professional, multi-disciplinary approach, Transition Management will ensure individuals receive their care and services in the most appropriate setting by transforming how Islanders move through our health care continuum in a seamless, coordinated, and planned fashion.

To support the design of Transition Management, Corpus Sanchez International was engaged to facilitate the discussion of a Design Team composed of stakeholders from across our health care system (see *Appendix A for the Design Team Membership*). Over the course of three days, the Design Team participated in a rapid design process to confirm there was a problem to solve, to identify a vision and attributes of the solution, to brainstorm on elements of the solution, and to provide advice on how to move forward.

The Design Team, which included membership from Public Health, Primary Health Care, Home Care, Mental Health and Addictions, and Acute Care, demonstrated a consistent and strong commitment to contributing to a renewed approach for how Islanders move through the health care system, while creating better working environments for providers of care. The ultimate conclusion from the process is that the existing approach for managing flow and access is not working and new ways of transitioning are possible and necessary to ensure a high quality, equitable, efficient and sustainable system to meet the needs of future generations of Islanders.

Information gained from the design session, combined with best practice evidence and prior experiences were compiled into this report to:

- Describe the challenges that impact how care is delivered across the continuum. The result, *Section 2.0 – Understanding the Need for Renewal.*
- Define Transition Management and establish a vision for what Transition Management must achieve. The result, *Section 3.0 – Explaining the ABCs of Transition Management.*
- Develop a model for how Transition Management will work. The result, *Section 4.0 – Building New “Roads” to Travel.*
- Define a roadmap to assist PEI in moving forward. The result, *Section 5.0 – Ensuring PEI Moves Forward.*

2.0 UNDERSTANDING THE NEED FOR RENEWAL

Prior to defining a vision and solution for Transition Management, it is first incumbent on PEI to confirm there is a clear need and benefit of pursuing a renewal.

WHAT ARE LOCAL STAKEHOLDERS SAYING?

Examination of Transition Management was originally motivated by the work of the provincial Model of Care Design Team and the work in Mental Health Services Planning, Home Care Planning, and Primary Care Planning which concluded:

- A high degree of consensus emerged that the system was not centred on the patient and that care is inappropriately fragmented. Core processes related to care coordination, discharge planning, team communication and better workflow were flagged as requiring change.
- A need to innovatively transition services from a hospital setting to care in the community by re-thinking who supports discharge planning and management, and by leveraging a pull methodology with caregivers who understand the continuum of care landscape.

This sentiment was validated by the provincial Transition Management Design Team which confirmed:

- Pursuing a design was unanimously supported by Design Team members.
- A high degree of variability exists under the current discharge management models. A survey completed by 119 respondents identified that:
 - Common approaches to discharging planning within a facility exist: always (18%), usually (44%), sometimes (33%), Never (5%).
 - Perceptions of successful planning and adherence to the plan varies using a five point scale from 1–Not so good (10%), 2 (15%), 3–OK (51%), 4 (17%), to 5–Excellent (7%).
 - Organizations who receive patients from other facilities are well communicated to: Always (4%), Usually (31%), Sometimes (65%), Never (0%).

WHAT ARE NATIONAL TRENDS AND EXPERIENCES TELLING US?

Review of national trends and experience confirm a clear need for action.

Need to manage a growing Alternate Level of Care (ALC) problem

- ALC cases accounted for 1.7 million hospital inpatient days a year in Canada (outside of Quebec and Manitoba) with 74,000 hospitalizations. This equates to almost 5,200 inpatient acute care hospital beds occupied by an ALC patient each day. These are people who are not in need or no longer need acute care or emergency department services and many could be more appropriately served in the community, but have no supports to get them home safely and get the care they need there. (CIHI, Analysis in Brief, January 2009)
- ALC patients typically account for our more frail patients. Eighty-two percent of ALC patients are 65 years of age or older with a mean age of 75.4 years. Dementia accounted for almost one-quarter of ALC hospitalizations and more than one third of ALC days in 2007-2008. Eighty-three percent of ALC patients were admitted to an acute care hospital through the emergency department, compared to 63% of non-ALC adult patients. (CIHI, Analysis in Brief, January 2009)
- Most ALC patients were discharged to a long-term care facility (43%), while 27% were discharged home and 12% died during their hospitalization.
- Each day a frail senior is in a hospital bed, 5% of their functioning is lost. (Community Health Services Integration in a Regionalized Model, Vancouver Coastal Health, Nancy Rigg, CRNCC Symposium, October 23, 2006, www.crncc.ca)
- Canada's senior population will grow by 100% by 2014, which will only exacerbate the current ALC crisis if something does not fundamentally change in the way the health care system delivers care to people. (MOHLTC Research Paper 13: Seniors' Health, Consultations on the Sustainability of Ontario's Health Care System, May 2006)

Need to change how individuals transition through the system

- Canada's health care system generally does not work as a system, but rather a series of silos. Within these silos, each sector's management of its own wait lists transfers pressure to other areas of the health care system, resulting in a lack of effective transition planning processes between sectors to ensure people are getting the right care by the right provider at the right time. This is evident in emergency departments and hospitals where delays occur in discharging patients due to challenges in accessing community-based services. The result - backlogs and the cancellation of surgeries because there are no hospital beds available, increasing wait times for surgeries.
- Many healthcare systems have built in controls to manage scarce resources. For example, access to scarce resources was only available at hospitals. However, over time, these controls have become unwarranted through innovations in healthcare that permit care in new settings (e.g., care and equipment previously available in a hospital is now available in the community, advancement in medications, new technologies supporting self care, availability of nurse practitioners in the community). These changes have shifted the paradigm – acute care hospitals are no longer the first point of access for care – new options exist and are evolving.
- In order for the hospital and emergency department to appropriately plan patient flow to provide emergency services, acute care and be able to perform scheduled surgeries, there needs to be in place within each hospital a straight-forward, user-friendly process to divert people from the emergency department or to discharge in a timely way those inpatients ready to transition back to the community. Currently in Canada, 19% of ALC patients are discharged to their home with no supports whatsoever. (CIHI Survey, "Alternatives to Acute Care?", Aleksandra Jokovic, Akerke Baibergenova, Kalyani Baldota & Kira Leeb, Healthcare Quarterly Vol. 9 No. 2, 2006, p. 22.)
- The Ontario Health Quality Council highlighted in its 2007 Annual Report that 9% of patients in Ontario's acute care beds do not need to be there, but cannot leave because: there is no residential healthcare facility or long-term care home available; the hospital doesn't have the proper organization in place to make sure people are discharged as soon as they're ready; there aren't community services to support recently discharged patients; or there are problems with transferring patients. (The Ontario Health Quality Council 2007 Report on Ontario's Health System, p.55)

Need to focus on the individual requiring care or services

- "Wait times are a symptom of a larger problem...Canadians need to support a transformation that puts patients at the centre of the system" (Postl 2006: 9).
- Primary Health Care must be a focus. The data on Canada's performance with regard to access to primary and specialty health care suggests a significant opportunity for improvement. For example, in 2004, Canada was identified as the country with the lowest percentage of citizens who could access a physician with a same-day appointment (27%), compared to the United States (33%), the United Kingdom (41%), Australia (54%) or New Zealand (60%) (College of Family Physicians of Canada 2006). With regard to access to specialty care, Canada ranked second lowest, with 57% of its citizens waiting at least four weeks to access specialty care, compared to the United States (60%), Australia (46%), the United Kingdom (40%), Germany (23%) and New Zealand (22%) (College of Family Physicians of Canada 2006).
- The challenge is navigating change across multiple healthcare service providers in diverse settings across the continuum of care. Change strategies that support access and integration include providing people-centred care.
- A focus must also be placed on reducing clinical variation. The reality and practice of improving system-wide access is complex, as different programs and sectors use varying approaches toward the same objectives of improving access, quality and efficiency.

Both local and national experiences confirm better management of flow and access to care across the continuum will improve health outcomes and lead to healthier communities. PEI has the unique opportunity to lead the development of a provincial, continuum-wide transition model that encompasses all sectors of care due to its motivation for change, support for this change, and current culture for better linkages.

3.0 EXPLAINING THE ABCS OF TRANSITION MANAGEMENT

To respond to the Needs for Renewal, it is important to have a clear and common understanding of what Transition Management is.

Many health systems are facing challenges relating to the system operating at overcapacity. Some suggest increasing resources; however, others argue that “merely increasing [the system’s] capacity will do little more than to broaden the large end of the funnel.”¹ They suggest critically exploring the structure of the current system and implementing necessary practice changes.

THE ABCS OF TRANSITIONS – A STARTING POINT

Transition Management is about **Timely Access**, to the **Best care and services**, **Coordinated across the broader Continuum**. Elaborating further:

- **A**ccess means an individual gets the services or care they need, when they need it
- **B**est Care is the provision of safe, dependable, quality care promoting good health outcomes
- **C**oordinated refers to developing a plan to ensure individuals receive their care in an organized and efficient manner, and that this care encompasses the broader care continuum

While many others have attempted to enhance transitions in healthcare, efforts are predominantly focused on the acute care sector, and have primarily sought to address discharges from hospital. As a result, the impacts have been limited as the delivery of health and care services extends beyond acute care alone. Hence this report has taken a very broad view of transitions.

While the concept of transitioning is not difficult to understand (*definition: movement, passage, or change from one position, state, stage to another*), the term “transition” is not commonly used in healthcare. Yet, effective transitions are the cornerstone of high quality, safe, efficient healthcare. Everyday, individuals transition from their home to a family health centre, or transition from their physician’s office to an emergency department, or transition from a nursing home to an inpatient bed, or transition from the ICU to a step-down bed, or hopefully transition from an inpatient bed back home via their primary health care physician with support from homecare. What make transitions difficult are the system barriers and impediments that block effective transitions.

Transition Management reflects planned and coordinated movement between sectors, within a sector, and within units of a sector enabling individuals to receive the right care, in the right environment/location, at the right time. The result: increased patient safety; reduced risk; enhanced patient, family and provider satisfaction; and improved capacity to ensure people and physical resources are effectively and efficiently utilized. To support the design of effective transitions, a provincial, inter-disciplinary approach must be leveraged to build a “made in PEI” solution that extends beyond the continuum of care from an individual’s home or long-term care residence, to primary health care, to public health, to acute care, to rehabilitation, to accessing mental health services, to homecare, and back home.

While Transitions may be a new term, providers must avoid becoming caught in semantics. Some sectors will use admission, transfer, and discharge to reflect transitions; others will describe the process of intake, referrals, and placements; while others use case management to reflect critical planning necessary to coordinate services. Any time an individual receives care or services across the continuum, they are transitioning.

¹ Laidlow. Duncan. (2006) Creating Patient Flow, January 3, 2006. Retrieved from www.interiorhealth.ca/NR/rdonlyres/8643D0E1-14FF-42ED-A0B6-8CC0BFDD5031/3474/JAN052006CREATEFLOW.pdf

UNDERSTANDING TRANSITIONS TODAY – PEI'S CURRENT STATE

Transitions in PEI are represented by a series of movements from one place to another; however these movements are not always coordinated, planned, or timely.

Some of the key challenges with transitions across the Island include:

- Barriers to transfer between hospitals for ongoing care – i.e. patients moving from QEH to another hospital, closer to their home, for a portion of their acute care stay. This process is reported to often come down to a “trade” of patients to provide a bed for a person requiring a higher level of care at QEH. At the same time, the community hospitals report they could provide the ongoing care but sense resistance from larger hospitals to support the transfer as early as possible. “They need to come out here and see what we do” was expressed during the Model of Care Design work.
- A transfer to post-acute care in a long-term care setting is a process that differs depending on the area of the Island you are from. Four placements committees, with four different processes, four different meeting schedules, etc all has the potential to lead to unnecessary delay.
- Gaps in services reportedly lead to patients not being able to access services such as adult day care, speech language, physiotherapy, occupational therapy etc . Yet where these services do exist, leaders report challenges with maintaining volumes. PEI needs to ensure that services are more widely understood, and that providers are equipped with the information needed to support conversations with families regarding options to support improved access.

Some of the key challenges with transitions across the sectors include:

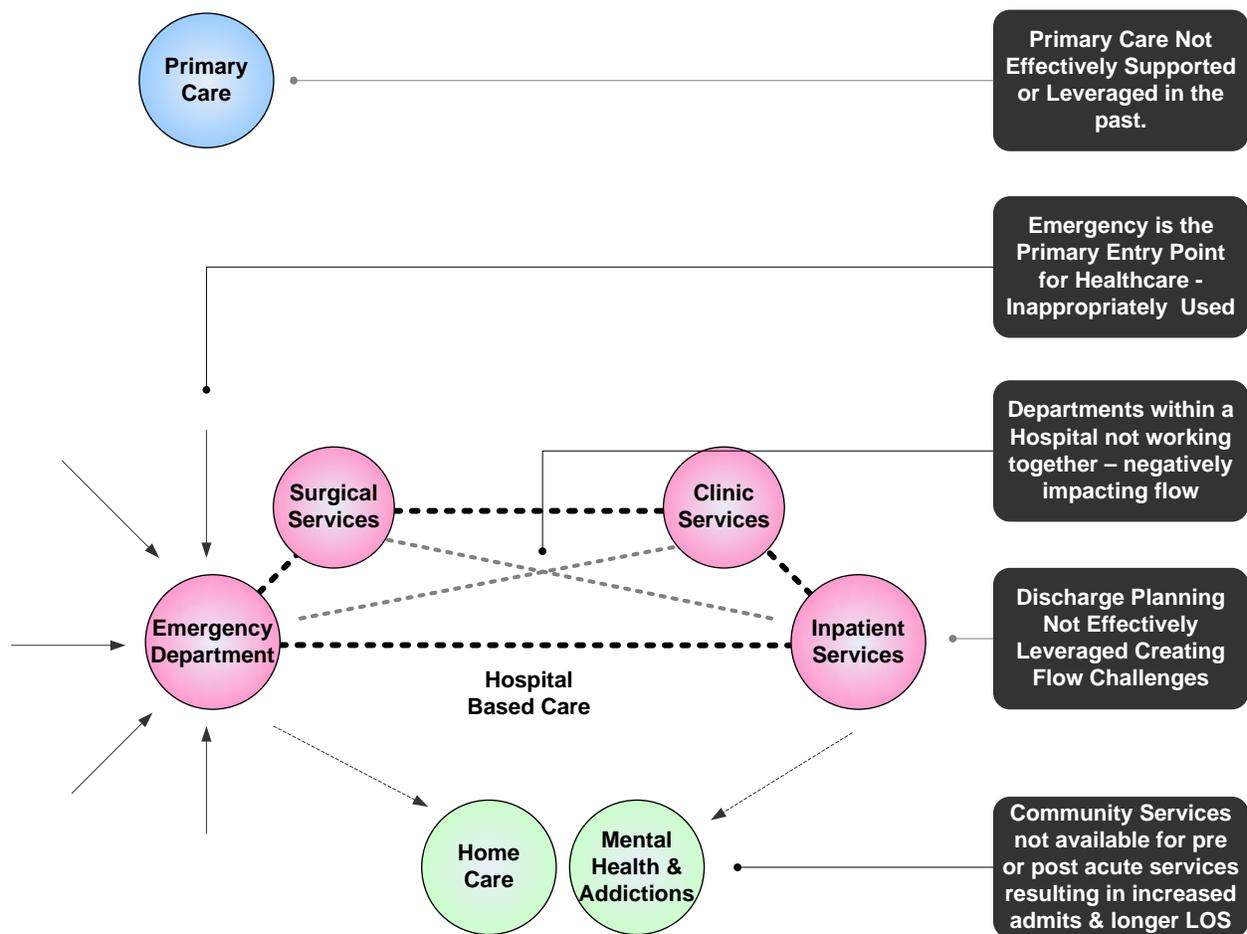
- In the past, Primary health care has not been effectively supported or leveraged. In the absence of good primary health care, opportunities to support prevention and good management of Islanders' health while they are at home can be lost. This ultimately places a greater strain on the acute and community care sectors. This gap has been acknowledged by the Department of Health, and there are current efforts to address via a new strategy and infrastructure (*PEI Integrated Health System Project - A Renewed Model of Primary Health Care in Prince Edward Island, September 2009*).
- Emergency is viewed as the front door to healthcare and may be used inappropriately in some cases. In the absence of strong community and primary health care access, Islanders may be using the ED when a more appropriate and effective care environment is more suitable. This also increases waiting times and reduces the effectiveness of the ED.
- Within the hospital, departments sometimes operate within silos as opposed to a continuum of care that is working together to provide care to a patient. As a result, internal delays are created and less-than-ideal handoffs occur which potentially impact a patient's outcome. Many hospitals have not established effective discharge approaches which typically elongate a patient's stay.
- Community services are typically leveraged post-acute care as opposed to being used pre- and post to assist a patient in managing their care while at home (e.g., community IV, renal management, wound protocols). Access to community services may also not be viewed as timely, thereby causing some hospital providers to keep a patient in the hospital for longer.
- There is a perception that has emerged on the Island that healthcare is acute care. Hence, hospitals have become the central hub for accessing care and services. However, with the advancement of technologies, innovative procedures, new medications, and the advancement of professionals, care can be provided in a number of new settings outside of hospitals. In fact, acute care hospitals may be the least appropriate setting for some individuals (e.g., unhealthy seniors).

The following diagram depicts some of the transition challenges across the various health care sectors. The most significant learning is that not only do sectors operate within their own individual silos, but even within a sector like hospital based care, there are silos amongst key services (ED, surgical services, clinic services, inpatient services – represented by the dotted lines).

It is important to understand that these silos are not new, nor should they be looked upon as failure of the system. They are a result for how healthcare has typically evolved. However, there is clear agreement that silos no longer work. As a result, every province, every jurisdiction is struggling with how to reduce silos to work in a more coordinated fashion.

Fortunately, PEI has acknowledged that need for reducing silos and has established a number of strategies including this Transition Management design, the Model of Care redesign, Primary Care renewal, Home care renewal, and Mental Health Services Planning.

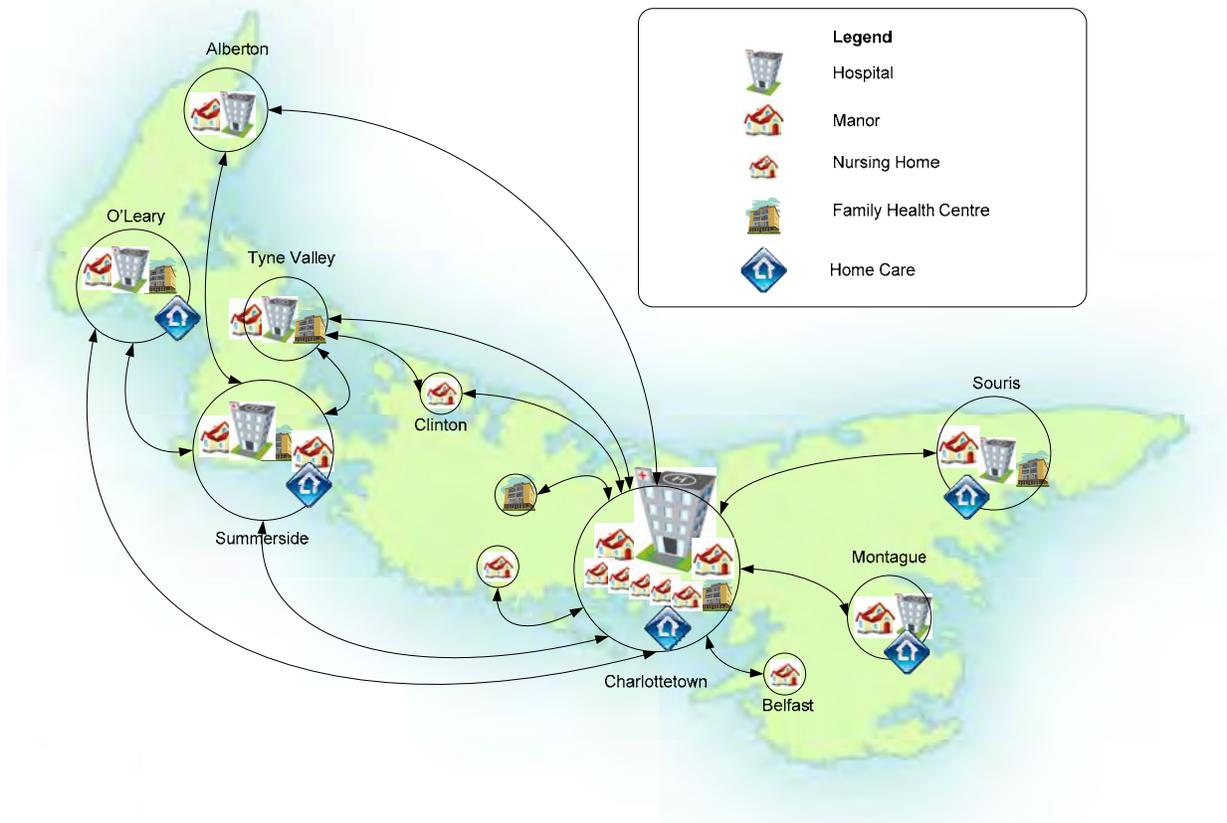
Current State of Transition Management



While transition across sectors is an important area of focus, Transition Management must also address transitions across the provincial landscape. The following diagram depicts some of the key transitions occurring everyday across the Island. The transitions are based on three factors: What services are required (e.g., hospital, manor, nursing home, family health centre, home care); Where are services available; and Where does the individual reside. As depicted by the arrows, individuals will typically receive services close to home unless these services are viewed as scarce and are only accessible in limited settings (e.g., Summerside and Charlottetown).

To support optimal service delivery, Transition Management must seek to:

- Optimize flow within each circle. Hence, Islanders living in their communities must have appropriate and timely access to services. However, resources and services may not be available within a circle due to capacity and resource challenges. In these situations, Islanders may need to travel for services.
- Optimize flow between circles. Where Islanders must travel for services, effective and efficient processes for accessing services must be established. In particular, access to the Summerside and Charlottetown hubs must be organized to ensure timely and appropriate access to scarce services. However, Transition Management must also support effective transfer out of these hubs back home in order to ensure capacity for others once the need for the scarce service is no longer required. A failure to develop a “decanting” capacity will lead to ongoing bottlenecks for accessing services. To support this flow, clear agreements must be established between sending and receiving organizations.



ESTABLISHING A VISION AND PRINCIPLES FOR TRANSITION MANAGEMENT – PEI’S FUTURE

To address these challenges, a vision was developed by the Transition Management Design Team.

Transition Management in PEI will be

A consistent and equitable process that ensures timely transition of an individual and their family across various sectors of healthcare ...

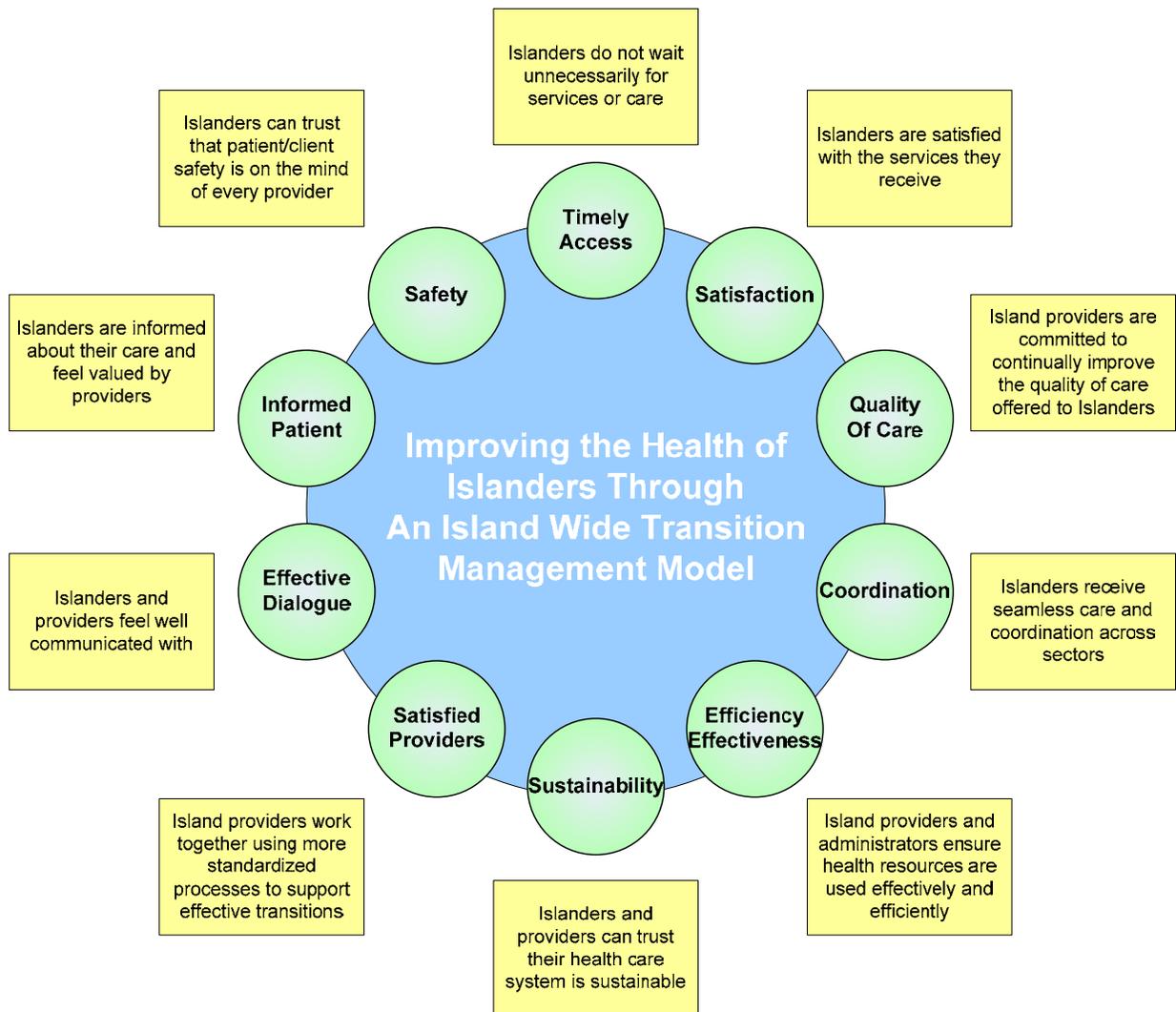
... utilizing clear communication, a predictable standardized well understood process, clear roles, and appropriate resources, beginning with the individual’s first encounter and focusing on optimal outcomes in appropriate settings.

To support the vision, the Design Team also defined key principles that must guide the development of any solutions and the ongoing functioning of a Transition Management system. The Island’s Transition Management will:

- Be conducted in partnership with individuals and their families;
- Be transparent and collaborative;
- Clearly define roles and accountabilities;
- Allow for best practice decision making based on need;
- Be consistent across the Island’s healthcare system in its application and in allocation of resources;
- Use an integrated health information system across the continuum;
- Provide public education on appropriate, efficient and effective access to care; and
- Establish and monitor key metrics in order to continually improve outcomes and service.

UNDERSTANDING THE BENEFITS OF EFFECTIVE TRANSITIONS – BENEFITS FOR ISLANDERS

Introduction of an island-wide approach to Transition Management will enhance patient safety, client and family satisfaction, quality of care, and ensure limited resources are utilized efficiently and effectively. Overall, Transition Management will enhance sustainability of all sectors within the healthcare system.



4.0 BUILDING NEW “ROADS” TO TRAVEL

UNDERSTANDING DESTINATIONS

Before building new “roads” to travel, it is important to first understand the destination or “where you want to go”. These are the types of services and care that may be provided across the various sectors. The following list identifies services that are currently available within a sector. However, the services may not be uniformly available across the Island due to resource limitations, variation in implementing and integrating services across different regions, geographical challenges and limitations, and variation in demand for services. *The list is provided as a sample and is not intended to be fully exhaustive of all current nor future services.*

Sector	Types of Services and Care
Primary Health Care	<ul style="list-style-type: none"> ▪ Public Health ▪ Physician, Nurse, Public Health nurse, Nurse Practitioner, PT, OT, SLP ▪ Disease prevention ▪ Chronic Disease prevention and management ▪ Healthy Living Strategy
Home Care	<ul style="list-style-type: none"> ▪ Clinical Services -Nursing, Physiotherapy, Occupational Therapy, Social Worker, Adult Protection, Dialysis, Palliative Care ▪ Limited - IV Therapy, pharmacy, dietician ▪ Personal Support Worker, Respite, LTC Assessment
Community Other Services	<ul style="list-style-type: none"> ▪ Home Maintenance ▪ Medical Equipment ▪ Meals on Wheels ▪ Private nursing and attendant care -
Community Congregate (Group) Services	<ul style="list-style-type: none"> ▪ Adult Day Programs ▪ Community Care Facilities ▪ Convalescent Care ▪ Ambulatory Services ▪ Geriatrician Services ▪ Hospice ▪ Diabetes Education, ▪ Long Term Care
Mental Health & Addictions	<ul style="list-style-type: none"> ▪ Community outreach, group counselling, addiction services, family programs ▪ Community psychiatrist, community mental health services, crisis response team ▪ Seniors mental health (limited) ▪ Methadone maintenance, smoking cessation, ▪ Forensic assessment, concurrent disorder group, Inpatient/Outpatient detox, rehab services, youth day program
Hospital Based Care	<ul style="list-style-type: none"> ▪ Emergency Department ▪ Ambulatory/Clinic services ▪ Inpatient, Critical Care ▪ Specialty Services – E.g. Oncology, Renal ▪ Surgery (OR) ▪ Mental Health ▪ Rehabilitation Services ▪ Diagnostic Services

NEW “ROADS” – A CONCEPTUAL MODEL FOR TRANSITIONS ACROSS THE CONTINUUM

To design a new model for how individuals receive care across PEI, a fundamental shift is required. This shift will create new “roads” to travel.

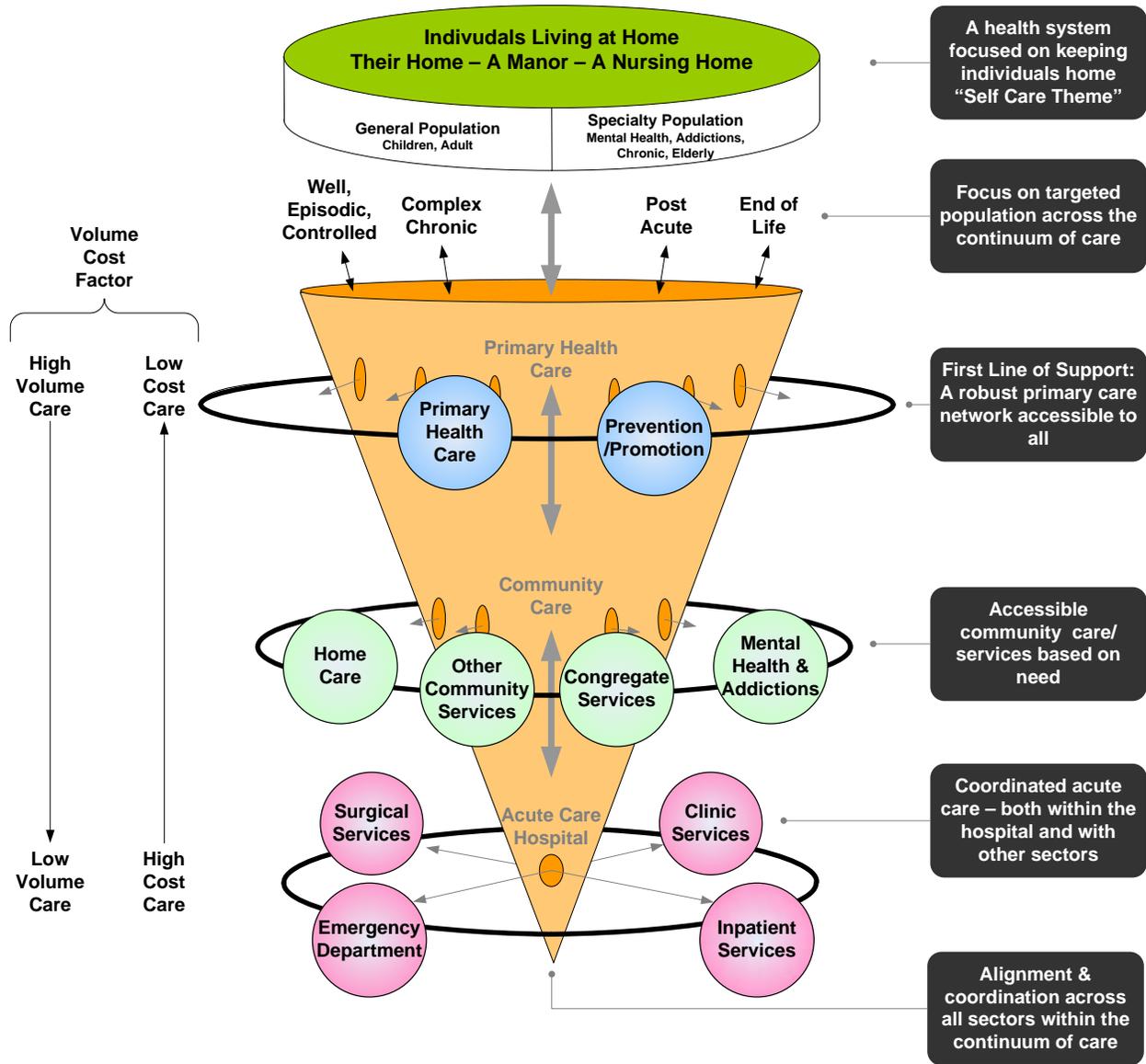
- A ‘care at home’ mindset must emerge and be supported – *A Self Care Theme*
- Care must be centered around specific populations to improve access to services in a timely manner – *Focus on Targeted Populations Across the Continuum*
- Primary health care must become the focal point – *A Robust Primary Health Care Network Accessible to All*
- Community care must be supported to enhance access and breadth of services – *Mix of Community Care Based on Need*
- Hospitals must be used for what they, and only they, can do – *Coordinated Acute Care*
- The shift will require sectors to work together differently – *Alignment & Coordination Across All Sectors Within the Continuum of Care*

The new model for Transition Management in PEI starts with individuals living at home. And home can be their own home, a manor, or a nursing home. The model acknowledges that individuals will have different needs. For example, they may be part of a general population with more episodic requirements for services or may be part of a speciality population (e.g., mental health, addictions, chronic care, elderly) requiring specialized services more frequently. As a result, the model defined targeted populations to ensure services are managed across the continuum in a coordinated fashion – these include the well and controlled individual, individuals with episodic care needs, the complex chronic individual, the post acute patient, and the end of life patient.

To ensure access to the right services at the right time, the model leverages a virtual funnel to direct individuals to the most appropriate sector. The first option for services is Primary Health Care and prevention/promotion services. These are service located very close to home and support the day-to-day management and well being of individuals. Where necessary, a second option for Community Care is available providing services close to home enabling patients to continue to live at home or helping them return home. A third option for services is Hospital Care reflecting the acute, more episodic care needs including access to the Emergency Department, Surgical Services, Ambulatory (Clinic) Services, and Inpatient Services. The funnel is predicated on the belief that ongoing innovations and advancements in technology, pharmacology, and surgical procedures will continually change what services can be provided in which setting. For example, what was previously a hospital based service may be supported in the community or a primary care setting (e.g., oxygen, IV), or what was previously managed in a physician office may become self care (e.g., diabetic monitoring).

Under the new model, each of the sectors no longer operate as a silo but rather collectively function as a coordinated continuum of services and care. Both within and between the silos, care providers work in a more coordinated manner enabling effective handoffs and management of the individual across this broader continuum of care.

Conceptual Transition Management Model



DEFINING NEW ROADS TO TRAVEL – RECOMMENDATIONS

To fundamentally change how Islanders receive care, a transformation of the “map of care” is required resulting in the creation of new roads. In some cases, these roads may not be new, but have not been used significantly and hence are in need of re-development to expand the breadth of services. In other cases, the roads are completely new and in need of construction to lay necessary foundations and capacity to support needs. Finally, in other cases, the roads may be over-travelled and in need of critical maintenance – this may require temporary or permanent detours. In all cases, the work necessary to support development of the roads are aimed at improving access to care and services for Islanders.

Development of new roads has been grouped into six categories for change:

- Building a Health System of Care Focused on Keeping Individuals Home – Self Care Theme;
- Focusing on Target Populations of Need;
- Enhancing a Robust Primary Health Care System;
- Accessing Community Services Based on Need;
- Coordinated Acute Care; and
- Alignment and Coordination Across All Sectors within the Continuum of Care

The following recommendation ideas were developed through two means: the first was through brainstorming and prioritization by the Design Team members, and the second was through a review of literature and best practices.

A Healthy System of Care Focused on Keeping Individuals Home – A Self Care Theme

A fundamental tenet of the new Transition Management model is to ensure selected services and care are available as close to home as possible. The benefits: a greater sense of satisfaction, dignity and autonomy by individuals and families receiving care and services; and a more cost-effective model as compared to expensive institutional long-term care.

To support a care at home philosophy, the following recommendations have been suggested:

- **Build a Culture that Supports Services Close to Home.** A shift in culture is required to transition from a hospital-based mindset to one where services are provided closer to home. This culture starts with self care, and then moves up the scale based on needs of the specific individual. Introduction of this culture will require a commitment to ongoing education of providers to ensure consistency in understanding and practice. To be successful, targeted areas of focus should be investigated initially where homecare is appropriate for the needs of the individual (e.g., Renal Care, IV Therapy, Speech and Language, Midwifery, Respiratory Therapy).
- **Enhance Self Management Programs.** To enhance self management, education interventions that engage individuals for 4 -7 weeks in community-based programs designed to “activate” them in the management of their chronic conditions must be developed. These types of programs assist individuals in managing their own symptoms and problems, and engage them in activities that maintain function and reduce health decline. As a result, individuals participate in diagnostic and treatment choices, and more effectively collaborate with their providers. The necessary education is provided by a mix of medical and non-medical professionals.
- **Involve Patients & Families In Care Planning Earlier.** Design Team members ranked the involvement of patients and families in their care planning process earlier as the number one priority. Innovative strategies are required to engage and inform patients and families. The strategies must be consistently applied. For example, development of policies and procedures supporting consistent application of planned family conversations on admission to an inpatient unit and a few days prior to discharge to ensure the home is readied and the family is prepared for a patient’s return home.
- **Reduce Barriers to Accessing Financial Supports.** Financial barriers must never extend a hospital stay beyond the need for acute care. All policies regarding additional supports requiring out of pocket costs (e.g., oxygen, specific housing options) should be reviewed and modified to remove any financial barrier. PEI is encouraged to identify key barriers which impact acute care hospitals and take a focused effort on high volume items. A focus on inter-departmental collaboration and cooperation to support “whole of government” policy is recommended; DSSS must be a partner.
- **Enable In-Home Assessment For Additional Supports.** To assist individuals to successfully manage care at home, enhanced access to in-home assessment should be developed in coordination with Community and Acute care providers. The aim of the assessment is to clearly identify specific areas of need that will help individuals to successfully live at home, and match these with available services (e.g., respiratory care, renal support). A joint Committee of providers from the continuum should be engaged to develop required services, including the prioritization of key areas of focus for consideration.
- **Establish Strategies to Avoid Premature Admissions to Long Term Care.** Studies indicate that a proportion of older adults reside in more restrictive settings than is necessary, or they do not receive the care they need. Berthelot and colleagues, in their analysis of Canadian data from the National Population Health Survey, found that 10% of adults 65 years of age and older with no disability resided in long-term care facilities². An American study suggests that for a sample of 3,170 older adults residing in long-term care facilities, it was estimated that 15% to 70% could be appropriately cared for in less restrictive settings. Given that contemporary models of care suggest older adults wish to live in their own communities for as long as possible and that home and community services will support this aim while being cost-effective³, opportunities to enhance the evaluation of potential candidates should be supported including the development of more

² Berthelot, J.-M., Martel, L., Legare, J., Trottier, H., & Houle, C. J. (2000). Living at home or in an institution: What makes the difference for seniors? [1996/97 data]. *Health Reports*, 11(4), 49.

³ Aging in Place. The Institute for Life Course and Aging, University of Toronto. Director: Dr. Lynn McDonald, Research Coordinator: Julia Janes, November 23, 2007

rigorous criteria and more interactive processes. Opportunities to develop education for families to help them cope with a family member should also be explored.

- **Diverting Clients to the Most Appropriate Care Setting.** Establish new communication strategies to change the mindset for where services should be accessed. The strategies must communicate alternative care environments that are more appropriate for serving the needs of clients. For example, in some jurisdictions television media has been successful in presenting various options for care instead of the ED being the first line of care for ailments more appropriately managed elsewhere.
- **Setting and Managing Expectations of Individuals and Families.** Develop and communicate a clear set of expectations of individuals and family members and their role in the care delivery process. While a historical focus has been to exclude family members, a more inclusive culture must be established to help manage expectations and reduce mistrust. Implementation of the expectations must be well understood by care providers and other stakeholders to ensure consistency and follow-through.
- **Ensure Effective Transportation Services.** To aid in management of care closer to home, some jurisdictions will require the development of transportation options. Unfortunately, existing capacity may be limited or focused on transportation into the larger cities. Given the close community nature of the Island, opportunities to build local community options, leverage traditional neighbour options, or develop a volunteer model typically seen in larger cities for cancer treatment may be more readily available (e.g., Potential partners include TPW, Community and Cultural Affairs, Department of Development).
- **Enhanced and Comprehensive Pre-Admission Screening.** Screening prior to an acute care procedure, typically surgical, is a key opportunity to assess a patient's ability to return home. While most Pre-Admission screening focuses on collecting pertinent information to help prepare a patient for surgery and provide necessary education, the pre-admission visit should be expanded to help ready the patient for returning home (e.g. understanding discharge time, expected date of discharge, items that will be necessary when they return home, follow-up services available in the community).
- **Establishing a Home First Approach.** Home First is a program to assist elderly patients in going home from hospital with support once their treatment has ended, instead of waiting for a long term care bed. The result, individual are in a more suitable environment, necessary services are available, individuals can make life changing decisions with their families from the comfort of their home, and there is a reduced chance of the individual's conditions deteriorating from long stays in the hospital due to lack of activity and common viral infections. The Home First has been successfully deployed in numerous jurisdictions in Ontario.

A Focus on Targeted Populations of Need

The new Transition Management model is built on understanding the needs of targeted populations and coordinating care to meet the needs. This “care coordination” is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.⁴

To support a focused care philosophy, the following recommendations have been suggested:

- **Targeted Strategies for Delivering Services to Populations.** To deliver appropriate, high quality, and efficient care, it is necessary to clearly identify populations of need and to define services that will support the population. The Transition Management Model has defined five populations of focus, including: the Well, Controlled and individuals requiring episodic care; the Frail Elderly; individuals living with Complex Chronic Conditions; individuals requiring Post-Acute care; and individuals at End of Life. Coordinated care interventions that identify patients within each of these foci will enable targeted approaches to reduce risk of future hospitalizations, support initial assessment and planning where required, support ongoing monitoring of patients’ symptoms and enable use of self-care where appropriate. Management approaches can vary from the provision of information to enhance self care for individuals capable of coordinating their own care, to full case management for a small subset of the population with clear needs. This approach for developing targeted strategies results in more effective use of limited resources while also improving outcomes and Islander’s well being. A starting point will be the Integrated Health System Care Pathway Project which will use evidence-based care pathways to enhance quality and efficiency of patient care, while also creating a standardized process for care, treatment, and documentation that supports clinical excellence and controls cost. The Project will develop clinical and patient care pathways for COPD, heart failure, and community-acquired pneumonia that will be implemented in the Models of Care showcase units at QEH Unit 3 and KCMH.
- **Define Admission Criteria and Map To Get Right Patient To Right Place And Care Within Community.** To best manage the targeted populations, clear and accurate identification is critical. Admission criteria are used to ensure the right patient is appropriately identified, and their specific needs are assessed to define the best plan of care. In many cases, a standard pathway (map) for patients within a targeted focus is defined, enabling modification based on a patient’s specific need. Note: Criteria and pathways must be standardized and communicated across all facilities.
- **Leverage Multi-Disciplinary, Collaborative Teams to Plan Care.** To assist in the management of targeted populations that span across multiple sectors, a multi-disciplinary collaborative team of providers will need to be brought together to define how the populations will be managed. Initially, planning will be focused on building standardized pathways where an individual crosses multiple sectors for high volume areas. For example, PEI should establish pathways for managing chronic diseases and strategies for besting managing the frail elderly. The Primary Health Care Working Group establishing a COPD care plan is an excellent example of a multi-disciplinary collaborative team. This care plan will be integrated with the UM COPD care plan.

⁴ The Promise of Care Coordination. Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses. A Report Commissioned by the National Coalition on Care Coordination (N3C) By Randall Brown, Ph.D., Mathematica Policy Research, Inc.

A Robust Primary Health Care System

Transition Management must be built on a foundation of effective primary health care. Primary health care is typically the first point of contact between citizens and the health system⁵. A refocused emphasis on an enhanced model of primary health care is needed to reduce over-reliance on bed-based care and to achieve future Island health system sustainability. The goals: Islanders can expect sustainable and safe local services, designed where possible to meet local needs and expectations, and specialized where necessary to ensure quality and safety; more services provided locally in doctors' offices or health centres with greater use of primary health care; and access to a core set of primary health care services within catchment areas.

To support a primary health care philosophy, the following recommendations have been suggested:

- **Primary Health Care Networks/ Catchment Areas.** Primary health care networks⁶ would be established and have defined management structures for medical, nursing and allied health leadership within a provincial structure. It is anticipated that the provincial structure would be responsible for the development of standards and would hold high level operational responsibility, ensuring consistent delivery of services. Administrative bases within networks would need to be established for effective management of programs. Within these catchment areas, primary health care leaders would work with other health leaders as part of integrated health management networks with defined terms of reference. All networks would require defined roles, relationships, protocols for physician access/referral and clinical intake processes to primary health care services. This has particular significance when allied services are not co-located. In addition, clear caseload/workload standards for all staff are required to balance demands with quality of care. Opportunities to provide evening and/or weekend services can be leveraged to reduce demand on the ED.
- **Defined Core Primary Health Care Teams.** Core primary health care teams would be comprised of a family physician, nursing staff (for example NP, RN, LPN), and administrative staff. Core teams would be located within a 30 km radius of 100 % of Islanders during regular business hours, Monday to Friday with extended hours available in each network. (It should be noted that geographic distance is not associated with improved health outcomes).
- **Ongoing Provincial Priority for Every Islander to have a Family Physician.** As identified by the College of Family Physicians of Canada (CFPC) and the Canadian Nursing Association (CNA), a vision that "All people in Canada will have access to a family practice/ primary health care setting that offers each person the opportunity to have his/ her care provided by each of the following: a personal family doctor and a registered nurse or nurse practitioner. Other health professionals, including pharmacists, physiotherapists, occupational therapists, dietitians, social workers and physician or medical office assistants, may also be part of these practices". PEI should continue to support their strategy for each Islander to have a family physician.
- **Enhance Physician-to-Physician Transitions.** A fundamental shift to enhancing the role of primary health care will be an improved communication between the primary health care physicians and acute care physicians in the ongoing care of patients in the community, both pre- and post-acute care. This important transfer of knowledge cannot be left up to inconsistent practice by only some physicians, but rather must be instituted as an expectation of care delivery. To support this end, communication must be enabled through technology and process enablers to limit workload and challenges on the part of the clinicians (e.g., electronic health records that automatically forward information to health care physicians upon discharge from a hospital). Some acute care hospitals may investigate options for leveraging a hospitalist model as a means to improve transition management.

⁵ PEI Integrated Health System Project - A Renewed Model of Primary Health Care in Prince Edward Island, September 2009.

⁶ The Renewed Model of Primary Health Care identified the following types of services within each catchment. Provide as an example only – to be confirmed and finalized. Chronic Disease prevention and management, Programs and strategies, Mental Health Services, Addictions Services, Speech Language Pathology, Community Nutrition, Public Health Programs, Diabetes Education, Targeted screening programs (i.e. hypertension), Aboriginal/French/International Immigrant / linguistic minority primary care, and Health Promotion and Prevention

Accessible Community Services Based on Need

Transition Management must also be built with a focus on keeping people home, and getting them back home once they've received care. To support this goal, community-based services and homecare services must become a focal point, and the community sector must be engaged as an active partner. This will require the community sector to make significant changes to ensure that it has the capacity and capability to effectively support patients if we aim to keep them in their homes or support them in returning home more quickly.

To support a community-based care philosophy, the following recommendations have been suggested:

- **A Needs-Based Response for Care Must be Supported.** Needs-based refers to providing needed services to an individual, and only those services. Unfortunately, healthcare has a tendency to provide more service than necessary, often because it is easier to bundle or group services. However, this is neither a good use of limited resources, nor is it good for patients. For example, an individual recently discharge from hospital may require OT support but other services like home maintenance are bundled in. While home maintenance may be a "nice to have", it may generally prevent the individually with getting back to their daily activities thereby delaying their recuperation. Under the Transition Management model, a gradient approach will be used, where individuals will get only the services they require. This approach is intended to strengthen the role of self-care.
- **Timely Access to Community-Based Services Enabling Diversion from Acute.** For acute care to be efficient and effective and to ensure patients receive appropriate care close to home, opportunities to provide specific services in the community should be supported to divert patients from acute care. This approach helps to maintain individuals "upstream" with the intent of deferring or potentially avoiding care in a hospital. For example, respite care, friendly visiting, diabetes management, and wound care. Currently, the Integrated Health System efforts have an Enterostomal Therapy (ET) project to initiate ET Nursing services for clients using best practice guidelines for wound care. The purpose of this project is to introduce a specialized service in Home Care to reduce demand on the ET service in hospitals and to ensure that evidence based practice is used to increase the healing rate of wounds; enable repatriation of patients with complex wounds to community hospitals; decrease length of stay in hospital for patients with complex wounds; and to formalise the consultant/educator role within Home Care, initially in Kings County. This program would potentially be rolled out provincially if successful.
- **Delivering Congregate Service Delivery Model for Resource-Limited Areas.** Congregate or group services provide an opportunity to bring groups of individuals together to receive services where resource capacity is limited or where group delivery is more efficient and effective. PEI should define focused areas and develop capacity in these areas to deliver services (e.g., IV therapy, diabetes education, youth day programs).
- **Enhance Access to Support Services at Home and in the Community.** The Design Team prioritized access to support services (e.g., occupational therapy, physiotherapy, social work) at home and in the community as an essential service under the new Transition Management model. Enhanced access will enable providers to meet with individuals in their own environment and support better assessment and care planning. However, due to resource limitations, a plan for deployment including assessment of impact should be developed. A starting point will be the Integrated Health System effort to have a Home Care Rehab Service project to improve the range of community based Physiotherapy (PT) and Occupational Therapy (OT) services to Home Care clients in King's County to enhance client capacity and provide greater support at home. A component of the project will be to implement a Falls Risk Management services for Kings County Home Care clients to mitigate falls particularly focused on seniors. This will also address the required operational practice of Accreditation Canada's Home Care Standards
- **Timely Access to Stand-alone Specialized Services.** Access to some stand-alone services (e.g., psycho-geriatric, youth mental health, psychiatry, detox beds, seniors' mental health, paediatric psychiatry) was viewed as too long. To address this need, new models for accessing standalone services should be developed that will enable more timely access to services. This recommendation is dependent on resource availability and should focus on key areas of need.

- **Access to Community Supports.** In addition to care support services (e.g., friendly visiting, attendant care), the community can play a significant role in the provision of community supports, like Meals On Wheels. A Committee should be established to identify options for community supports and define key priorities for the Department of Health to review as part of a business case process.

PEI is also initiating a **Home Care Project for Program Planning and Case Management**. The purpose of this project is to carry out program planning and design to develop recommendations to guide long term strategic investment in home care services. Specific areas of focus in this project will include: defining the “Basket of Services” that PEI’s Home Care Program (Home Care) should provide, including potential acute care replacement services; defining a provincial intake, assessment, and a case management model for continuing care; assessing the impact of and incorporating the Model of Care (MoC) Project work on the provincial Home Care model in keeping with specific target populations (e.g. frail elderly), defining a single access point for service; identifying appropriate assessment tools and processes; identifying training needs; identifying legislative implications and requirements; identifying adult day programming needs; establishing a Care Giver Support Strategy; promoting the development of an Information Technology/Information Management (IT/IM) plan, developing a change management plan to facilitate transitions internal and external to the provincial Home Care Program, and determining Business Process Re-design requirements. *The consultants view this work as pivotal to developing a needed Home Care service and support this work in moving forward.*

Coordinated Acute Care

Within acute care, the most fundamental requirement to support a Transition Management agenda is to enhance the handoffs amongst the providers and departments. The movement to a seamless care environment will not only improve a patient's journey through the episode of care (e.g., shorter length of stay), but will also ensure the most appropriate services are delivered. A coordinated acute care environment will also enhance coordination with the community and primary health care sectors.

To enhance coordination within the acute care sector, the following recommendations have been suggested:

- **Establish A Plan Of Care Including Setting Expected Date Of Discharge Within 24 Hours Of Admission.** To ensure timely and appropriate discharges, each and every patient should be assigned an expected discharge within 24 hours of admission to an inpatient unit. The expected date of discharge should generally be part of a discharge plan developed by nursing. The plan should be reviewed daily and communicated with the care team, the patient and family members.
- **Introduce Policy For Issuing Discharge Orders Day Before Discharge.** To support a more efficient and timely discharge, a policy should be established that discharge orders should be issued the day before discharge. To avoid extended lengths of stay due to this policy, lengths of stays will be tracked against benchmarks. To support the discharge process, strategies such as goal/criteria based discharges and nurse led discharges will be examined.
- **Evaluation And Reporting Of Adherence To Advanced Discharge Planning.** An expected date of discharge must be set for every patient within 24 hours of admission to an inpatient unit. Adherence to reporting compliance of setting a date, and overall utilization management examining length of stay should be monitored. To support utilization and patient flow efforts, the Integrated Health System initiative is launching a project to create a utilization management position at the QEH to manage bed utilization and patient flow from admission to discharge with attention given to vulnerable populations at risk for exceeding the ELOS. This project is expected to improve utilization of inpatient beds at the QEH while ensuring patients are receiving the right care, in the right setting, for the appropriate duration of time and have the correct status.
- **Direct ED Admission to Desired Unit.** Design Team members identified frustration in not always being able to admit a patient to the desired unit from the ED. A new policy and procedure needs to be developed to support the ED in admitting patients to where they ultimately need to go.
- **Access to Outpatient Diagnostic and Therapeutic Services to Reduce Inpatient Stays.** To ensure a delay in discharge is not attributed to delayed access to diagnostic and therapeutic services, access to key services like imaging should be made available while a patient is still in the hospital or a scheduled appointment within 24 hours of discharge established prior to leaving the hospital.
- **Access to Referral Services 24/7.** To limit delays in referral, a 24/7 referral service should be developed to ensure timely assessment, planning and ultimately discharge of patients to the next required service.
- **Enhance ED Flow.** To support improved flow through the ED, targets should be established to ensure all admitted patients in the ED are transferred within the current facility or to other facilities within 6 hours.
- **Establish Geriatric Assessment Teams.** To support more effective and timely assessment of the elderly to identify if they can go home with supports or require additional services, a Geriatric Assessment Team can be utilized to conduct targeted assessments using a multi-disciplinary team of a nurse practitioner, occupational therapist, physiotherapist, social worker for example. The Team would receive requests for assessments from inpatient units or the ED.

- **Establish Repatriation Policies Amongst Acute Care Hospitals.** To assist patients to return to hospitals closer to home and reduce institutional barriers, repatriation agreements should be developed to reduce politics and enable timely transfer. Repatriation agreements from the QEH and Prince County hospitals will be critical to enable these regional providers to decant activity so they can continue to receive activity from the province.
- **Update Policy for Long Term Care Admissions.** The policy for long term care admissions including the 1st Bed Policy should be updated and redeployed consistently across PEI.
- **Establish Transitional Care Capacity.** Transitional care interventions engage patients while in the hospital and then continue to follow-up over the 4 - 6 weeks after discharge to ensure patients understand how to adhere to post-discharge instructions for medication and self-care, recognize symptoms that signify potential complications requiring immediate attention, and make and keep follow-up appointments with their primary health care physicians. Due to limited resources, transitional care capacity should be developed for specific populations of need in partnership with the community and other key stakeholders.
- **Screening And Assessment Completed Within Acute Care In Partnership With Liaison From Community-Based Care.** Joint planning for patients amongst acute and community-based providers will lead to patient-centred decisions regarding care and support development of the best of care irrespective of care environments. While models of community care providers completing assessments in acute care (e.g., ED, inpatient units) are not new, a planned approach for collaborating was viewed as an opportunity to develop new options. Currently, a Home Care Community Liaison Program⁷ is being implemented to create a provincial approach for returning seniors to their homes safely, securely and with support as quickly as possible after requiring acute care services is needed within PEI's Health System. The Home Care Community Liaison Nursing positions in the QEH, PCH and Community Hospitals whose responsibility will be to assess potential and existing home care clients and determine what supports are needed to quickly, safely and securely return clients home through screening, assessment and appropriate community intervention
- **Access to Timely and Comprehensive Information Across the Continuum.** With the investments in Cerner, PEI should investigate and pursue opportunities to leverage the EHR to support greater access and distribution to comprehensive information. In addition, Primary Health Care and Home Care will also require technological solutions (e.g., EMR) to enhance communication within their sector and with other providers along the continuum.
- **Establish Orientation/Education/Training for Staff, Politicians and others To Understand Options.** Education must be a central focus for transition management to be successful. Education strategies must be inclusive of the many stakeholders, and viewed as a continuous requirement, as opposed to a one-time event.
- **Introduce Transition Management Awareness into Orientation Session.** Develop a transition management awareness session to be integrated into organizational/program orientation sessions. The material will clearly outline the necessity for timely discharge planning, provide an overview of transition management policies and procedures, and provide necessary reference material. This recommendation will help to ensure all staff works in a consistent fashion through a common understanding of the discharge process.
- **Leverage Information and Technology Enablers to Enhance Communication.** Assess/review technology tools to support improved communication between admitting units, ED and housekeeping that will enhance patient flow (e.g., tools for housekeeping to be notified of bed turnovers - pages, call centres, and bed boards/notification systems).
- **Access to Necessary Medication Supplies and Equipment Post Acute.** To ensure patients have the necessary medication supplies and equipment to enable discharge from hospital as early as possible and to assist with smooth transitions to home, a pilot is being established to support provision of two weeks of necessary supplies post acute for home care patients.

⁷ Home Care Community Liaison Program sponsored by Cecil Villard, Director – Community Hospitals and Continuing Care and project managed by Will MacDonald as part of the Integrated Health System Projects

- **Leverage Outpatient Capacity and Resources.** As inpatient and ED areas continue to become “locked”, hospitals must pursue alternative relief valves. Ambulatory or outpatient services represent an important opportunity to redirect care and services to an environment that is often more cost effective and appropriate for the patient. PEI should assess opportunities for expanding ambulatory outpatient environments and resources to address patient flow challenges. For example, opportunities to discharge a patient from an inpatient unit sooner and having the required diagnostic procedure completed as an outpatient, or enabling access to a PT or OT consult within a clinic setting, or enabling an ED patient to be referred to a clinic the next day as opposed to waiting in the ED.
- **Discharge on Weekend.** Acute care facilities should determine the impact/benefit of weekend discharges for any population of patients, and if material, develop a supporting process.
- **Enhance Communication Within the Care Team Using SBAR.** Implement SBAR (**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation) tool to improve communication between physicians and other care providers. Policies and procedures should be developed and supported by appropriate education for program staff to enshrine SBAR as a key communication tool within the organization when communicating around key patient care issues.
- **Streamline Medication Reconciliation.** To enhance patient safety, medication reconciliation must be successfully implemented in all acute care hospitals, with linkages back to primary health care, home care and long term care.
- **Leverage Reports and Metrics Used By Leaders.** To ensure ongoing success of transition management, information and the reporting of data to leadership who will monitor targets and act as required must be a key deliverable. A clinical decision support capacity should be developed, either at the Department of Health or within acute care facilities to develop reporting metrics and support ongoing provision of data.

Alignment & Coordination Across Sectors Within the Continuum of Care

Finally, the last foundation for Transition Management is to ensure the continuum of care and the sectors within it are connected in a seamless fashion. Supporting this concept requires a clear shift in thinking that care for the patient does not end in any single sector - care does not end in a hospital, and care does not end in the community. Care is continuous, and while episodes of care may end, care for the person continues. Hence, success will only come from connecting the continuum.

To enhance care across the continuum, the following recommendations have been suggested:

- **Enhance Application of Telehealth.** To deliver clinical care and professional education among health care providers and patients, telehealth can transform how patients receive needed health care by extending and enhancing access to healthcare providers and eliminating barriers to care. Using two-way videoconferencing systems and tele-diagnostic instruments like digital stethoscopes, otoscopes and patient examination cameras, telehealth can enable clinical consultations to support more timely diagnosis and treatment; improve health outcomes; reduce travel, time and expenses; and ability to receive care close to home.
- **1-800 Access to Healthcare Advice.** To support appropriate navigation of the system, a 1-800 number to call and speak to a nurse should be made available to the residents of PEI. The Province should investigate opportunities to link into either the Nova Scotia or New Brunswick solution as opposed to building a system.
- **Establish Inter-Sectorial and Inter-Site Agreements to Support Flow.** To enable flow between facilities, organizations should identify opportunities for creating protocols (with standards and metrics) to enhance coordination (e.g., mental health with acute, acute with acute, acute with community) between sectors. For example, a protocol may be established for a patient to receive follow-up services in a community setting after being discharged from the hospital. For example, the protocol will clearly identify the type of follow-up care required, describe the individual's status based on criteria to ensure they are ready for the community-based follow-up, identify the goals of the community-based care and the expected duration for services.
- **Enhance Patient/Family Education Through Easy Access To Information.** To ensure patients and family members are well informed, websites or other traditional communication materials (print, radio, and television) should be leveraged. Information must be clearly written for the reader and easily accessible to enable patients to make choices about how and where they receive care.
- **Home at Last Program.** Home at Last is an innovative program developed in Ontario to help seniors living alone or with an older caregiver get home and settled quickly and safely following their emergency department visit or hospital stay. The program addresses "social admissions" or patients who were "failing to thrive" in the community.
- **Standardized Referral Processes.** Movement toward a single, standardized referral form, consistent triage language and consistent communication strategies will enable referring healthcare providers to follow explicit referral requirements. This improved communication between primary health care and specialty care will increase the quality of the referral information and ultimately enhance patient care and safety.

5.0 ENSURING PEI MOVES FORWARD

To transition from a conceptual model for Transition Management to actual deployment and realization of benefits, a mobilization (Roll-Out) plan is required to ensure necessary planning, design, training, communication, and overall preparation of all care providers across the continuum. The plan must enable a fundamental shift in culture from one that is sector-based to one that is people-based. In our experience, this shift will require the development of trust: trust that all sectors will work together to support the transition of an individual across the system; trust that the required capacity to deliver services is available when they are required; trust that necessary investments to realize the benefits will be supported by Leadership.

DEFINING A HIGH LEVEL ROADMAP FOR MOVING FORWARD

To assist PEI in their planning, CSI has prepared a high-level, four phase plan to support the process in moving forward. Key phases include:

- **Phase 1 – Endorsement of the Transition Management Model.** This is a critical step to ensure provincial endorsement of the model. This includes acceptance of the report by the Transition Management Steering Committee, after which approval from the Department of Health must be received, with clear agreement for moving forward from each Model of Care implementation showcase unit including support from each participating site leadership. Once this has been achieved, a communication effort must quickly be deployed to engage, inform, and educate all stakeholders across the broader continuum.
- **Phase 2 – Detailed Planning and Endorsement of an Implementation Plan.** Development of a detailed implementation plan is an important step to ensuring clear identification of which elements of the Transition Management Model will be pursued and when they will be implemented. A Planning Committee should be established and assigned responsibility for developing the plan which will include clear identification of what specific recommendations will be implemented, the required activities to support implementation, and identification of timelines and resource requirements. The plan must detail work associated with each of the sectors. Once complete, the plan will be reviewed by the Steering Committee to ensure it is achievable, and that the benefits will meet the intent of the model. The Transition Management Steering Committee will then work with the Model of Care Implementation Teams to determine how the implementation can be integrated within the broader model of care rollout. This process is expected to be iterative. Once a viable plan has been developed, the plan will be endorsed by the Department of Health. To support this work, a project manager should be assigned to provide guidance and oversight to the process.
- **Phase 3 – Defining Evaluation Metrics to Monitor Impact on Transitions.** Once the rollout plan has been determined, detailed planning to identify key performance indicators to monitor and assess the impact of the new transition management model will be completed. The KPIs will be based on the continuum and will attempt to leverage currently available information or system generated information wherever possible.
- **Phase 4 – Developing a Storyboard to Clearly Communicate the What, Why, When and How.** Change is always difficult, especially when there are a number of unknowns. To address this challenge, and learning from the recent rollout of the model of care initiative, a very clear storyboard should be developed that describes how care will be different for Islanders; what they need to do differently; how providers' work will be different and what they will do differently; what the rollout will look like. This storyboard will then be translated into a communication strategy to ensure stakeholders clearly understand the intent in simple language. The communication strategy will be deployed prior to rollout of the Transition Management model.
- **Phase 5 – Rollout of the Transition Management Model.** It is expected that a phased rollout of the Transition Management model will be pursued in collaboration with the Model of Care initiative and identified demonstration projects within Primary Health Care, Mental Health, and Home Care.

Following deployment at the Showcase Units, it is expected that the Transition Management model will be deployed province-wide.

MANAGING OBSTACLES

As part of the design process, Design Team members were asked to identify the key obstacles that may stand in the way of successfully deploying Transition Management. The following points have been included to better inform planning activities moving forward.

- Leadership will be critical to moving the transition agenda forward. Support for moving forward must be clearly communicated, and necessary investments of time, money, and other resources secured to support the necessary change. It is important that leadership at all levels, from both within and outside the health system, be supportive and cooperative in moving the initiative forward, regardless of the impact to individual leaders.
- Clear understanding of the intent of transition management must be well understood by the public. Transition management's goal of ensuring the ABCs (great access, best care, coordinated across the continuum) is the desired objective. Design Team members expressed concern of the lingering effects of prior change initiatives that were not successful and issues with some people remaining cynical of likelihood of success.
- Physician, clinician and leadership support at all facilities across the continuum must buy into the Transition Management agenda. This will potentially require the largest change to transition away from a silo mentality to a system of care mentality.
- Clearly established accountability. Due to the magnitude of the change, clear accountability must be assigned and understood. As part of accountability, system leaders must communicate and support the new model. Design Team members expressed a tiredness of the "all talk, no action" phenomenon.
- Deployment of the Transition Management approach must be based on consistency across the Island. The approach will fail when the system does not work as a system. This will require a new level of communication, development and adherence to consistent policies,

LEVERAGING ENABLERS

Design Team members were also asked to comment on potential enablers that will support the implementation of a new Transition Management model.

- A "Can-Do" capacity. There is a readiness and want for change. The Design Team noted that limited resources have meant resourcefulness on the part of staff to get things done. This capacity must be leveraged.
- Dedicated Providers. PEI has dedicated providers who deliver care to Islanders everyday. These wonderful, caring professionals who make it work must be part of the solution.
- There is an appreciation that current political support and will for change will be fundamental to getting Transition Management off the ground.
- Investments in technology can be leveraged to support the flow and communication process through more system based solutions that can simplify work and reduce negative impacts on providers. Expansion of efforts like telehealth, 1-800-Need-Care, and other technological advancements can be part of a solution.
- The size of PEI supports system-wide, provincial solutions.
- With the work completed to-date to build a One Island Healthcare System, relationships have formed across disciplines and locations that will make it easier to work together towards common goals.
- The early success with Model of Care rollout provides hope that Transition Management can be successful.

PRIORITIZATION OF RECOMMENDATIONS

To assist PEI in moving forward, recommendations must be grouped and prioritized to establish a viable implementation plan. We recommend the following approach.

- Each recommendation will be Grouped based on two criteria:
 - Each recommendation has been assigned to one of six categories for change (Building a Health System of Care Focused on Keeping Individuals Home – Self Care Theme; Focusing on Target Populations of Need; Enhancing a Robust Primary Health Care System; Accessing Community Services Based on Need; Coordinated Acute Care; and Alignment and Coordination Across All Sectors within the Continuum of Care).
 - Within each category, recommendations will be grouped as either a People, Process, Information, or Technology change.
- Each recommendation will be Prioritized based on three criteria:
 - Impact – the overall benefit for implementing the recommendation
 - Implementation Challenge – the degree of difficulty for implementing the recommendation
 - Time to Deliver – the time to implement the recommendation if implementation started today

DESIGN TEAM MEMBERSHIP

The Transition Design Team was comprised of 87 health care system stakeholders and leaders.

Acute Care

Marion	Dowling	QEH Director of Nursing
Mary	Harris	QEH Associate Director of Nursing
Kerry	Moore	QEH Manager of Social Work
Marion	Younker	QEH Nursing Supervisor
Anita	MacKenzie	QEH RN Nurse Manager
Elizabeth	Boys-Leath	QEH Clinical Leader
Sheila	MacLeod	QEH Medical Nurse Manager
Trudy	Myatt	QEH Surgery Nurse Manager
Debbie	Flood-Vickerso	QEH Nurse Manager Unit 9
Darlene	Ward	QEH Unit 9 Clinical Leader
Cathy	Livingstone	QEH Manager Admitting
Noreen	Landrigan	QEH Charge Nurse Unit 3
Jean	McKearney	QEH Med. Social Worker
Kelley	Rayner	QEH Director of Hospital Services
Heather	Cutcliffe	QEH Manager - Physical Medicine
Kim	Blue	QEH Accounting Services Manager
Dr. Joanne	McGinn	QEH ER Physician
Angela	Carragher	PCH Physiotherapist Clinical Resource
Fgayle	MacKinnon	PCH Nursing Supervisor
Vicki	MacLean	PCH ED Nurse Manager
Jane	MacDonald	PCH Medical Nurse Manager
Velma	Rogers	PCH Discharge Planner
Mary	Duchesne	PCH Admitting (PCH Admitting Mgr)
Dr. Peter	MacKean	PCH PCH Chief of Staff
Patsy	Mulligan	PCH RN
Marcia	Leard	PCH Clinical Leader
Judy	Adams	Western RN
Cathy	Cahill	Souris Team Leader
Edna	Miller	Souris Director of Nursing
Elaine	MacLennan	Kings County RN (Head Nurse)
Anne	Keuper	Kings County Physiotherapist Allied Health
Jean	Fallis	Kings County Administrator
Kelly	Blanchard	Stewart Memorial RN Coordinator
Gayle	Lamont	Stewart Memorial Administrator

Home Care

Geri	Morrison	Queens Regional Hospital Team Leader HSW
Danita	McInnis	Home Care - Souris Team Leader
Barbie	Lavers	Home Care and Support-Montague/Riverview Manor Team Leader
Eva	Walsh	QHR-CC/Home Care & Support Team Leader
Myrt	MacNevin	QHR-CC/Home Care & Support Social Worker
Judy	MacIsaac	WPH Home Care Social Worker
Janie	Butler	Home Care (Queens) Nursing Home Admissions Coordinator
Colleen	Dawson	Home Care - Summerside Care Coordinator
Leah	Kinch	Home Care O'Leary Analyst
Joanne	Chisholm	Health-Home Care Souris & Montague Palliative Care Case Manager / Souis Hosp.
Maureen	Forrest	QHR-CC/Home Care & Support Home Care Nurse - RN
Mary	Arsenault	Hillsborough Hospital Home Care Manager
Mary	Sullivan	Home Care & Support Provincial Coordinator
Paula	Caulier	Home Care & Support - Prince County Supervisor
Marilee	Miller	QHR - CC/Home Care & Support Occupational Therapist
Deina	Perry	Queens County Hospital Care Physiotherapist
Elaine	Campbell	Provincial Geriatrics Services Coordinator
Calvin	Joudrie	Dept. of Health; Community Hosp &CC Manager
Kelly	Stavert	Home Care - Summerside Social Worker

Mental Health and Addictions

Colin	Campbell	QHR-PHC/CMH/Richmond Centre Manager
Dr. Abder	Sahouli	Mental Health and Addition Services Clinical Psychologist
Amy	Gaudet	Community Mental Health & Addictions West Nursing Supervisor
Margaret	Kennedy	Dept. of Health Provincial Manager
Theresa	Lewis	Community Add.&MH East Montague/Souris A/ Coordinator
Michael	Whitlock	Community Mental Health - Summerside Clinical Social Worker / Supervisor
Donna	MacIntyre	WPH Community Mental Health Children's Mental Health Therapist
Cory	Woodford	McGill Centre - Comm. Mental Health Manager
Donna	Bruce	Richmond Ctr. Adult Clinical Services Supervisor
Donna	Birch	PCH - Health /Community Mental Health Coordinator
Dr. Denise	Lea	PATF in Mt. Herbert Addictions Physician
Bobbi Jo	Flynn	Department of Health/Mental Health Community Mental Health Clinical Leader
Donna	MacDonald	Mt. Herbert Prov. Addictions Comm. Liaison Nurse
Carol	Hameline	Comm. Mental Health& Addict.-East Clinical Intake Therapist
Dr. Mark	Triantafillou	Department of Health Director of Mental Health
Darren	O'Handley	Provincial Addictions Treatment Facility Program Manager

Health Centres

Zahra	Jamal	Four Neighbourhoods/Dept.of Health Family Physician
Dr. Soha	Rizk	Souris Hospital & EKFC Family Physician
Marion	Godfrey	East Kings Family Health Ctr. Clinical Resource
Lisa	Shaffer	Four Neighbourhoods/Dept.of Health Primary Care Coordinator
Donna	MacAusland	Dept of Health Primary Care analyst

Department of Health

Joanne	Donahoe	PM Office Project Manager
Kathy	Jones	PM Office Project Manager
Will	MacDonald	PM Office Project Manager
Liz	Sajdak	Corporate Relations Program Analyst
Garth	Waite	PM Office Senior Planner/Policy Advisor
Cindy	Gregory	PM Office Communications
Faye	Kingdon	PM Office Project Manager
Cynthia	Bryanton	PCH Director of Hospital Services
Rhea	Jenkins	DSS&S Disability Supports
Patricia	MacDonald	Dept. of Health RN Unit # 9; Disability Supports-SS
Anna	Duffy	PEI Senior Citizen Ld. Seniors Secretariat
Susan	Birt	PEI Senior Citizen Federation Board Member
Dona	Francis	Dept. of Health Progam Analyst

SURVEY SUMMARY

To assist the Design Team to understand the current state of Transition Management (formerly titled Discharge Management), a survey was developed and responded to by 119 individuals. Overall, results identified variation in perspectives for the breadth of services and overall impact of existing transition management activities. *While a detailed review of findings was not completed, the consultants suggest that the goal should be to have a higher proportion of respondents in the Always, Usually, Excellent and Very Good categories.* The following highlight some key findings.

Is there a common approach to planning patient discharges from your facility?	Always 15%	Usually 37%	Sometimes 27%	Never 4%	NA ⁸ 17%
Are there written discharge management policies and procedures?	Always 13%	Usually 12%	Sometimes 22%	Never 19%	NA 35%
How would you rate your organization's ability to plan and successfully follow a discharge plan?	Excellent 7%	Very Good 17%	Good 51%	OK 15%	Not Good 10%
For organizations receiving patients, do you feel well communicated to?	Always 3%	Usually 27%	Sometimes 56%	Never	NA 14%
Is there a common, standardized approach for discharge management followed by most?	Always 6%	Usually 29%	Sometimes 36%	Never 11%	NA 18%

The following table outlines who is most accountable for discharge management. *While discharge management may be part of many providers' roles, the following table suggests that there must be clarity regarding "who is responsible for what" to ensure no individual gets missed.*

	MD	RN	LPN	Charge	Case Mgr	SW	PT/OT/RT	Mngt	Family	Pharmacy
Admission	37%	42%	23%	22%	9%	16%	9%	4%	31%	13%
Assign ELOS	24%	15%	1%	8%	10%	11%	7%	3%	9%	0%
Care Planning	23%	34%	13%	19%	12%	16%	15%	1%	12%	4%
Monitoring Adherence to Plan	20%	34%	16%	18%	13%	14%	13%	5%	12%	3%
Discharge Planning	24%	31%	8%	21%	13%	23%	17%	2%	19%	6%
Multi-Disciplinary Rounds	16%	29%	8%	22%	16%	29%	28%	6%	7%	13%
Involved in Bed Utilization	16%	14%	2%	18%	3%	3%	2%	18%	0%	1%
Make Referrals	29%	29%	4%	17%	13%	19%	18%	1%	5%	2%

⁸ NA = Not Applicable

SUMMARY OF RECOMMENDATIONS

A Healthy System of Care Focused on Keeping Individuals Home – A Self Care Theme

- **Build a Culture that Supports Services Close to Home.** A shift in culture is required to transition from a hospital-based mindset to one where services are provided closer to home. This culture starts with self care, and then moves up the scale based on needs of the specific individual. Introduction of this culture will require a commitment to ongoing education of providers to ensure consistency in understanding and practice. To be successful, targeted areas of focus should be investigated initially where homecare is appropriate for the needs of the individual (e.g., Renal Care, IV Therapy, Speech and Language, Midwifery, Respiratory Therapy).
- **Enhance Self Management Programs.** To enhance self management, education interventions that engage individuals for 4 -7 weeks in community-based programs designed to “activate” them in the management of their chronic conditions must be developed. These types of programs assist individuals in managing their own symptoms and problems, and engage them in activities that maintain function and reduce health decline. As a result, individuals participate in diagnostic and treatment choices, and more effectively collaborate with their providers. The necessary education is provided by a mix of medical and non-medical professionals.
- **Involve Patients & Families In Care Planning Earlier.** Design Team members ranked the involvement of patients and families in their care planning process earlier as the number one priority. Innovative strategies are required to engage and inform patients and families. The strategies must be consistently applied. For example, development of policies and procedures supporting consistent application of planned family conversations on admission to an inpatient unit and a few days prior to discharge to ensure the home is readied and the family is prepared for a patient’s return home.
- **Reduce Barriers to Accessing Financial Supports.** Financial barriers must never extend a hospital stay beyond the need for acute care. All policies regarding additional supports requiring out of pocket costs (e.g., oxygen, specific housing options) should be reviewed and modified to remove any financial barrier. PEI is encouraged to identify key barriers which impact acute care hospitals and take a focused effort on high volume items. A focus on inter-departmental collaboration and cooperation to support “whole of government” policy is recommended; DSSS must be a partner.
- **Enable In-Home Assessment For Additional Supports.** To assist individuals to successfully manage care at home, enhanced access to in-home assessment should be developed in coordination with Community and Acute care providers. The aim of the assessment is to clearly identify specific areas of need that will help individuals to successfully live at home, and match these with available services (e.g., respiratory care, renal support). A joint Committee of providers from the continuum should be engaged to develop required services, including the prioritization of key areas of focus for consideration.
- **Establish Strategies to Avoid Premature Admissions to Long Term Care.** Studies indicate that a proportion of older adults reside in more restrictive settings than is necessary, or they do not receive the care they need. Berthelot and colleagues, in their analysis of Canadian data from the National Population Health Survey, found that 10% of adults 65 years of age and older with no disability resided in long-term care facilities⁹. An American study suggests that for a sample of 3,170 older adults residing in long-term care facilities, it was estimated that 15% to 70% could be appropriately cared for in less restrictive settings. Given that contemporary models of care suggest older adults wish to live in their own communities for as long as possible and that home and community services will support this aim while being cost-effective¹⁰, opportunities to enhance the evaluation of potential candidates should be supported including the development of more rigorous criteria and more interactive processes. Opportunities to develop education for families to help them cope with a family member should also be explored.

⁹ Berthelot, J.-M., Martel, L., Legare, J., Trottier, H., & Houle, C. J. (2000). Living at home or in an institution: What makes the difference for seniors? [1996/97 data]. *Health Reports*, 11(4), 49.

¹⁰ Aging in Place. The Institute for Life Course and Aging, University of Toronto. Director: Dr. Lynn McDonald, Research Coordinator: Julia Janes, November 23, 2007

- **Diverting Clients to the Most Appropriate Care Setting.** Establish new communication strategies to change the mindset for where services should be accessed. The strategies must communicate alternative care environments that are more appropriate for serving the needs of clients. For example, in some jurisdictions television media has been successful in presenting various options for care instead of the ED being the first line of care for ailments more appropriately managed elsewhere.
- **Setting and Managing Expectations of Individuals and Families.** Develop and communicate a clear set of expectations of individuals and family members and their role in the care delivery process. While a historical focus has been to exclude family members, a more inclusive culture must be established to help manage expectations and reduce mistrust. Implementation of the expectations must be well understood by care providers and other stakeholders to ensure consistency and follow-through.
- **Ensure Effective Transportation Services.** To aid in management of care closer to home, some jurisdictions will require the development of transportation options. Unfortunately, existing capacity may be limited or focused on transportation into the larger cities. Given the close community nature of the Island, opportunities to build local community options, leverage traditional neighbour options, or develop a volunteer model typically seen in larger cities for cancer treatment may be more readily available (e.g., Potential partners include TPW, Community and Cultural Affairs, Department of Development).
- **Enhanced and Comprehensive Pre-Admission Screening.** Screening prior to an acute care procedure, typically surgical, is a key opportunity to assess a patient's ability to return home. While most Pre-Admission screening focuses on collecting pertinent information to help prepare a patient for surgery and provide necessary education, the pre-admission visit should be expanded to help ready the patient for returning home (e.g. understanding discharge time, expected date of discharge, items that will be necessary when they return home, follow-up services available in the community).
- **Establishing a Home First Approach.** Home First is a program to assist elderly patients in going home from hospital with support once their treatment has ended, instead of waiting for a long term care bed. The result, individuals are in a more suitable environment, necessary services are available, individuals can make life changing decisions with their families from the comfort of their home, and there is a reduced chance of the individual's conditions deteriorating from long stays in the hospital due to lack of activity and common viral infections. The Home First has been successfully deployed in numerous jurisdictions in Ontario.

A Focus on Targeted Populations of Need

- **Targeted Strategies for Delivering Services to Populations.** To deliver appropriate, high quality, and efficient care, it is necessary to clearly identify populations of need and to define services that will support the population. The Transition Management Model has defined five populations of focus, including: the Well, Controlled and individuals requiring episodic care; the Frail Elderly; individuals living with Complex Chronic Conditions; individuals requiring Post-Acute care; and individuals at End of Life. Coordinated care interventions that identify patients within each of these foci will enable targeted approaches to reduce risk of future hospitalizations, support initial assessment and planning where required, support ongoing monitoring of patients' symptoms and enable use of self-care where appropriate. Management approaches can vary from the provision of information to enhance self care for individuals capable of coordinating their own care, to full case management for a small subset of the population with clear needs. This approach for developing targeted strategies results in more effective use of limited resources while also improving outcomes and Islander's well being. A starting point will be the Integrated Health System Care Pathway Project which will use evidence-based care pathways to enhance quality and efficiency of patient care, while also creating a standardized process for care, treatment, and documentation that supports clinical excellence and controls cost. The Project will develop clinical and patient care pathways for COPD, heart failure, and community-acquired pneumonia that will be implemented in the Models of Care showcase units at QEH Unit 3 and KCMH.
- **Define Admission Criteria and Map To Get Right Patient To Right Place And Care Within Community.** To best manage the targeted populations, clear and accurate identification is critical. Admission criteria are used to ensure the right patient is appropriately identified, and

their specific needs are assessed to define the best plan of care. In many cases, a standard pathway (map) for patients within a targeted focus is defined, enabling modification based on a patient's specific need. Note: Criteria and pathways must be standardized and communicated across all facilities.

- **Leverage Multi-Disciplinary, Collaborative Teams to Plan Care.** To assist in the management of targeted populations that span across multiple sectors, a multi-disciplinary collaborative team of providers will need to be brought together to define how the populations will be managed. Initially, planning will be focused on building standardized pathways where an individual crosses multiple sectors for high volume areas. For example, PEI should establish pathways for managing chronic diseases and strategies for besting managing the frail elderly. The Primary Health Care Working Group establishing a COPD care plan is an excellent example of a multi-disciplinary collaborative team. This care plan will be integrated with the UM COPD care plan.

A Robust Primary Health Care System

- **Primary Health Care Networks/ Catchment Areas.** Primary health care networks¹¹ would be established and have defined management structures for medical, nursing and allied health leadership within a provincial structure. It is anticipated that the provincial structure would be responsible for the development of standards and would hold high level operational responsibility, ensuring consistent delivery of services. Administrative bases within networks would need to be established for effective management of programs. Within these catchment areas, primary health care leaders would work with other health leaders as part of integrated health management networks with defined terms of reference. All networks would require defined roles, relationships, protocols for physician access/referral and clinical intake processes to primary health care services. This has particular significance when allied services are not co-located. In addition, clear caseload/workload standards for all staff are required to balance demands with quality of care. Opportunities to provide evening and/or weekend services can be leveraged to reduce demand on the ED.
- **Defined Core Primary Health Care Teams.** Core primary health care teams would be comprised of a family physician, nursing staff (for example NP, RN, LPN), and administrative staff. Core teams would be located within a 30 km radius of 100 % of Islanders during regular business hours, Monday to Friday with extended hours available in each network. (It should be noted that geographic distance is not associated with improved health outcomes).
- **Ongoing Provincial Priority for Every Islander to have a Family Physician.** As identified by the College of Family Physicians of Canada (CFPC) and the Canadian Nursing Association (CNA), a vision that "All people in Canada will have access to a family practice/ primary health care setting that offers each person the opportunity to have his/ her care provided by each of the following: a personal family doctor and a registered nurse or nurse practitioner. Other health professionals, including pharmacists, physiotherapists, occupational therapists, dietitians, social workers and physician or medical office assistants, may also be part of these practices". PEI should continue to support their strategy for each Islander to have a family physician.
- **Enhance Physician-to-Physician Transitions.** A fundamental shift to enhancing the role of primary health care will be an improved communication between the primary health care physicians and acute care physicians in the ongoing care of patients in the community, both pre- and post-acute care. This important transfer of knowledge cannot be left up to inconsistent practice by only some physicians, but rather must be instituted as an expectation of care delivery. To support this end, communication must be enabled through technology and process enablers to limit workload and challenges on the part of the clinicians (e.g., electronic health records that automatically forward information to health care physicians upon discharge from a hospital).

¹¹ The Renewed Model of Primary Health Care identified the following types of services within each catchment. Provide as an example only – to be confirmed and finalized. Chronic Disease prevention and management, Programs and strategies, Mental Health Services, Addictions Services, Speech Language Pathology, Community Nutrition, Public Health Programs, Diabetes Education, Targeted screening programs (i.e. hypertension), Aboriginal/French/International Immigrant / linguistic minority primary care, and Health Promotion and Prevention

Some acute care hospitals may investigate options for leveraging a hospitalist model as a means to improve transition management.

Accessible Community Services Based on Need

- **A Needs-Based Response for Care Must be Supported.** Needs-based refers to providing needed services to an individual, and only those services. Unfortunately, healthcare has a tendency to provide more service than necessary, often because it is easier to bundle or group services. However, this is neither a good use of limited resources, nor is it good for patients. For example, an individual recently discharge from hospital may require OT support but other services like home maintenance are bundled in. While home maintenance may be a “nice to have”, it may generally prevent the individually with getting back to their daily activities thereby delaying their recuperation. Under the Transition Management model, a gradient approach will be used, where individuals will get only the services they require. This approach is intended to strengthen the role of self-care.
- **Timely Access to Community-Based Services Enabling Diversion from Acute.** For acute care to be efficient and effective and to ensure patients receive appropriate care close to home, opportunities to provide specific services in the community should be supported to divert patients from acute care. This approach helps to maintain individuals “upstream” with the intent of deferring or potentially avoiding care in a hospital. For example, respite care, friendly visiting, diabetes management, and wound care. Currently, the Integrated Health System efforts have an Enterostomal Therapy (ET) project to initiate ET Nursing services for clients using best practice guidelines for wound care. The purpose of this project is to introduce a specialized service in Home Care to reduce demand on the ET service in hospitals and to ensure that evidence based practice is used to increase the healing rate of wounds; enable repatriation of patients with complex wounds to community hospitals; decrease length of stay in hospital for patients with complex wounds; and to formalise the consultant/educator role within Home Care, initially in Kings County. This program would potentially be rolled out provincially if successful.
- **Delivering Congregate Service Delivery Model for Resource-Limited Areas.** Congregate or group services provide an opportunity to bring groups of individuals together to receive services where resource capacity is limited or where group delivery is more efficient and effective. PEI should define focused areas and develop capacity in these areas to deliver services (e.g., IV therapy, diabetes education, youth day programs).
- **Enhance Access to Support Services at Home and in the Community.** The Design Team prioritized access to support services (e.g., occupational therapy, physiotherapy, social work) at home and in the community as an essential service under the new Transition Management model. Enhanced access will enable providers to meet with individuals in their own environment and support better assessment and care planning. However, due to resource limitations, a plan for deployment including assessment of impact should be developed. A starting point will be the Integrated Health System effort to have a Home Care Rehab Service project to improve the range of community based Physiotherapy (PT) and Occupational Therapy (OT) services to Home Care clients in King’s County to enhance client capacity and provide greater support at home. A component of the project will be to implement a Falls Risk Management services for Kings County Home Care clients to mitigate falls particularly focused on seniors. This will also address the required operational practice of Accreditation Canada’s Home Care Standards
- **Timely Access to Stand-alone Specialized Services.** Access to some stand-alone services (e.g., psycho-geriatric, youth mental health, psychiatry, detox beds, seniors’ mental health, paediatric psychiatry) was viewed as too long. To address this need, new models for accessing standalone services should be developed that will enable more timely access to services. This recommendation is dependent on resource availability and should focus on key areas of need.
- **Access to Community Supports.** In addition to care support services (e.g., friendly visiting, attendant care), the community can play a significant role in the provision of community supports, like Meals On Wheels. A Committee should be established to identify options for community supports and define key priorities for the Department of Health to review as part of a business case process.

Coordinated Acute Care

- **Establish A Plan Of Care Including Setting Expected Date Of Discharge Within 24 Hours Of Admission.** To ensure timely and appropriate discharges, each and every patient should be assigned an expected discharge within 24 hours of admission to an inpatient unit. The expected date of discharge should generally be part of a discharge plan developed by nursing. The plan should be reviewed daily and communicated with the care team, the patient and family members.
- **Introduce Policy For Issuing Discharge Orders Day Before Discharge.** To support a more efficient and timely discharge, a policy should be established that discharge orders should be issued the day before discharge. To avoid extended lengths of stay due to this policy, lengths of stays will be tracked against benchmarks. To support the discharge process, strategies such as goal/criteria based discharges and nurse led discharges will be examined.
- **Evaluation And Reporting Of Adherence To Advanced Discharge Planning.** An expected date of discharge must be set for every patient within 24 hours of admission to an inpatient unit. Adherence to reporting compliance of setting a date, and overall utilization management examining length of stay should be monitored. To support utilization and patient flow efforts, the Integrated Health System initiative is launching a project to create a utilization management position at the QEH to manage bed utilization and patient flow from admission to discharge with attention given to vulnerable populations at risk for exceeding the ELOS. This project is expected to improve utilization of inpatient beds at the QEH while ensuring patients are receiving the right care, in the right setting, for the appropriate duration of time and have the correct status.
- **Direct ED Admission to Desired Unit.** Design Team members identified frustration in not always being able to admit a patient to the desired unit from the ED. A new policy and procedure needs to be developed to support the ED in admitting patients to where they ultimately need to go.
- **Access to Outpatient Diagnostic and Therapeutic Services to Reduce Inpatient Stays.** To ensure a delay in discharge is not attributed to delayed access to diagnostic and therapeutic services, access to key services like imaging should be made available while a patient is still in the hospital or a scheduled appointment within 24 hours of discharge established prior to leaving the hospital.
- **Access to Referral Services 24/7.** To limit delays in referral, a 24/7 referral service should be developed to ensure timely assessment, planning and ultimately discharge of patients to the next required service.
- **Enhance ED Flow.** To support improved flow through the ED, targets should be established to ensure all admitted patients in the ED are transferred within the current facility or to other facilities within 6 hours.
- **Establish Geriatric Assessment Teams.** To support more effective and timely assessment of the elderly to identify if they can go home with supports or require additional services, a Geriatric Assessment Team can be utilized to conduct targeted assessments using a multi-disciplinary team of a nurse practitioner, occupational therapist, physiotherapist, social worker for example. The Team would receive requests for assessments from inpatient units or the ED.
- **Establish Repatriation Policies Amongst Acute Care Hospitals.** To assist patients to return to hospitals closer to home and reduce institutional barriers, repatriation agreements should be developed to reduce politics and enable timely transfer. Repatriation agreements from the QEH and Prince County hospitals will be critical to enable these regional providers to decant activity so they can continue to receive activity from the province.
- **Update Policy for Long Term Care Admissions.** The policy for long term care admissions including the 1st Bed Policy should be updated and redeployed consistently across PEI.
- **Establish Transitional Care Capacity.** Transitional care interventions engage patients while in the hospital and then continue to follow-up over the 4 - 6 weeks after discharge to ensure patients understand how to adhere to post-discharge instructions for medication and self-care, recognize symptoms that signify potential complications requiring immediate attention, and make and keep follow-up appointments with their primary health care physicians. Due to limited resources,

transitional care capacity should be developed for specific populations of need in partnership with the community and other key stakeholders.

- **Screening And Assessment Completed Within Acute Care In Partnership With Liaison From Community-Based Care.** Joint planning for patients amongst acute and community-based providers will lead to patient-centred decisions regarding care and support development of the best of care irrespective of care environments. While models of community care providers completing assessments in acute care (e.g., ED, inpatient units) are not new, a planned approach for collaborating was viewed as an opportunity to develop new options. Currently, a Home Care Community Liaison Program¹² is being implemented to create a provincial approach for returning seniors to their homes safely, securely and with support as quickly as possible after requiring acute care services is needed within PEI's Health System. The Home Care Community Liaison Nursing positions in the QEH, PCH and Community Hospitals whose responsibility will be to assess potential and existing home care clients and determine what supports are needed to quickly, safely and securely return clients home through screening, assessment and appropriate community intervention
- **Access to Timely and Comprehensive Information Across the Continuum.** With the investments in Cerner, PEI should investigate and pursue opportunities to leverage the EHR to support greater access and distribution to comprehensive information. In addition, Primary Health Care and Home Care will also require technological solutions (e.g., EMR) to enhance communication within their sector and with other providers along the continuum.
- **Establish Orientation/Education/Training for Staff, Politicians and others To Understand Options.** Education must be a central focus for transition management to be successful. Education strategies must be inclusive of the many stakeholders, and viewed as a continuous requirement, as opposed to a one-time event.
- **Introduce Transition Management Awareness into Orientation Session.** Develop a transition management awareness session to be integrated into organizational/program orientation sessions. The material will clearly outline the necessity for timely discharge planning, provide an overview of transition management policies and procedures, and provide necessary reference material. This recommendation will help to ensure all staff works in a consistent fashion through a common understanding of the discharge process.
- **Leverage Information and Technology Enablers to Enhance Communication.** Assess/review technology tools to support improved communication between admitting units, ED and housekeeping that will enhance patient flow (e.g., tools for housekeeping to be notified of bed turnovers - pages, call centres, and bed boards/notification systems).
- **Access to Necessary Medication Supplies and Equipment Post Acute.** To ensure patients have the necessary medication supplies and equipment to enable discharge from hospital as early as possible and to assist with smooth transitions to home, a pilot is being established to support provision of two weeks of necessary supplies post acute for home care patients.
- **Leverage Outpatient Capacity and Resources.** As inpatient and ED areas continue to become "locked", hospitals must pursue alternative relief valves. Ambulatory or outpatient services represent an important opportunity to redirect care and services to an environment that is often more cost effective and appropriate for the patient. PEI should assess opportunities for expanding ambulatory outpatient environments and resources to address patient flow challenges. For example, opportunities to discharge a patient from an inpatient unit sooner and having the required diagnostic procedure completed as an outpatient, or enabling access to a PT or OT consult within a clinic setting, or enabling an ED patient to be referred to a clinic the next day as opposed to waiting in the ED.
- **Discharge on Weekend.** Acute care facilities should determine the impact/benefit of weekend discharges for any population of patients, and if material, develop a supporting process.

¹² Home Care Community Liaison Program sponsored by Cecil Villard, Director – Community Hospitals and Continuing Care and project managed by Will MacDonald as part of the Integrated Health System Projects

- **Enhance Communication Within the Care Team Using SBAR.** Implement SBAR (Situation, Background, Assessment, Recommendation) tool to improve communication between physicians and other care providers. Policies and procedures should be developed and supported by appropriate education for program staff to enshrine SBAR as a key communication tool within the organization when communicating around key patient care issues.
- **Streamline Medication Reconciliation.** To enhance patient safety, medication reconciliation must be successfully implemented in all acute care hospitals, with linkages back to primary health care, home care and long term care.
- **Leverage Reports and Metrics Used By Leaders.** To ensure ongoing success of transition management, information and the reporting of data to leadership who will monitor targets and act as required must be a key deliverable. A clinical decision support capacity should be developed, either at the Department of Health or within acute care facilities to develop reporting metrics and support ongoing provision of data.

Alignment & Coordination Across Sectors Within the Continuum of Care

- **Enhance Application of Telehealth.** To deliver clinical care and professional education among health care providers and patients, telehealth can transform how patients receive needed health care by extending and enhancing access to healthcare providers and eliminating barriers to care. Using two-way videoconferencing systems and tele-diagnostic instruments like digital stethoscopes, otoscopes and patient examination cameras, telehealth can enable clinical consultations to support more timely diagnosis and treatment; improve health outcomes; reduce travel, time and expenses; and ability to receive care close to home.
- **1-800 Access to Healthcare Advice.** To support appropriate navigation of the system, a 1-800 number to call and speak to a nurse should be made available to the residents of PEI. The Province should investigate opportunities to link into either the Nova Scotia or New Brunswick solution as opposed to building a system.
- **Establish Inter-Sectorial and Inter-Site Agreements to Support Flow.** To enable flow between facilities, organizations should identify opportunities for creating protocols (with standards and metrics) to enhance coordination (e.g., mental health with acute, acute with acute, acute with community) between sectors. For example, a protocol may be established for a patient to receive follow-up services in a community setting after being discharged from the hospital. For example, the protocol will clearly identify the type of follow-up care required, describe the individual's status based on criteria to ensure they are ready for the community-based follow-up, identify the goals of the community-based care and the expected duration for services.
- **Enhance Patient/Family Education Through Easy Access To Information.** To ensure patients and family members are well informed, websites or other traditional communication materials (print, radio, and television) should be leveraged. Information must be clearly written for the reader and easily accessible to enable patients to make choices about how and where they receive care.
- **Home at Last Program.** Home at Last is an innovative program developed in Ontario to help seniors living alone or with an older caregiver get home and settled quickly and safely following their emergency department visit or hospital stay. The program addresses "social admissions" or patients who were "failing to thrive" in the community.
- **Standardized Referral Processes.** Movement toward a single, standardized referral form, consistent triage language and consistent communication strategies will enable referring healthcare providers to follow explicit referral requirements. This improved communication between primary health care and specialty care will increase the quality of the referral information and ultimately enhance patient care and safety.