A New Model of Care for PEI

Building a Plan to Improve Care Delivery Across the Continuum

SEPTEMBER, 2009

TABLE OF CONTENTS

1.0 EXECUTIVE SUMMARY

The PEI Model of Care initiative stems from the review of the province's health care system conducted by Corpus Sanchez International. The report, released in November 2008, contained a number of recommendations to transform the delivery of healthcare, which have been incorporated into the Department of Health's *Integrated Health Services Plan*.

Chronic shortages of healthcare professionals, the ever-increasing costs to provide care, and the increasing demands on the system underline the need to redesign the way healthcare services are provided to patients.

Model of Care represents an important building block in the move towards *One Island Health System*. The key to moving forward as a single system is the need to develop processes and system of care delivery that reach beyond traditional borders such as hospitals or home care and link the care delivery teams through a revitalized focus on care planning and coordination.

The newly designed model of care envisions a strong focus on these roles, embedding these roles into the care processes in the home and community settings and linking care partners from primary care right through the continuum to better meet the needs of the patients being served.

In the new model, an inter-professional design team was struck to consider what a redesigned delivery system would look like, the concerns and issues such a system would bring, and ways to ensure a successful implementation. An aggressive schedule of design sessions was implemented, which allowed input from staff and stakeholders across the province.

Emerging from the design sessions was a consensus that patients and families should be at the centre of care, and have a role to play in the delivery of care. Additionally, care should be available and delivered closer to home and community, communication and the availability of information is key, and all members of collaborative care teams need to practice to their applicable full scopes of practice. Thinking outside the box and keeping the welfare of the patient at the forefront guided the development of the model and will continue to be an important tenet as the province moves towards implementation.

A change in the delivery system necessitates a change in the way each healthcare professional functions within that new delivery model. Discussions in the redesign sessions centred on the notion of a collaborative approach to delivering care: each provider's function should be clearly defined, and each provider will be aware of the others' roles. Re-thinking how staff in nursing, allied health professions, in primary and community based care, and in homecare function and interact will help in providing quality care closer to home.

The design team identified issues relating to people, processes, information-sharing and technology which need to be addressed in order to assist in the transition. In order for the change to succeed, a commitment to collaboration and coordination, effective communication, ongoing education, and strong and effective leadership are needed.

To implement the new model of care, four phases are suggested to achieve success. Phase 1 calls for endorsement of the model of care design. Phase 2 sees the formation of teams to support the roll-out of the plan. Phase 3 sees plans developed for performance and evaluation. Phase 4, showcase readiness, fine tunes the plan for implementation in the showcase units.

2.0 INTRODUCTION, BACKGROUND AND CONTEXT

In November 2008, the final report of the Corpus Sanchez International (CSI) review of the health care system in Prince Edward Island was released. That report outlined a series of recommendations that the Department of Health (DOH) have subsequently incorporated into an Integrated Health Services Project Plan (IHSP) – a plan that is built around the Government's vision for *One Island Health Care System.*

Included in the Project Plan is the vision for the system that says: *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.*

The IHSP goals are: *Quality, Efficiency, Equity and Sustainability.* To support these goals, initiatives are planned or underway in a number of areas and sectors, including:

- Primary Health Care;
- Home Care and Continuing Care;
- Integrated Acute Care;
- Provincial Services;
- System Enablers;
- Utilization Management;
- Medical Leadership; and
- Model of Care.

This report is focused on the last of the initiatives outlined above – *Model of Care*. Model of Care is ultimately about the way health care services are organized and delivered, and the way provider roles are structured, supported and deployed.

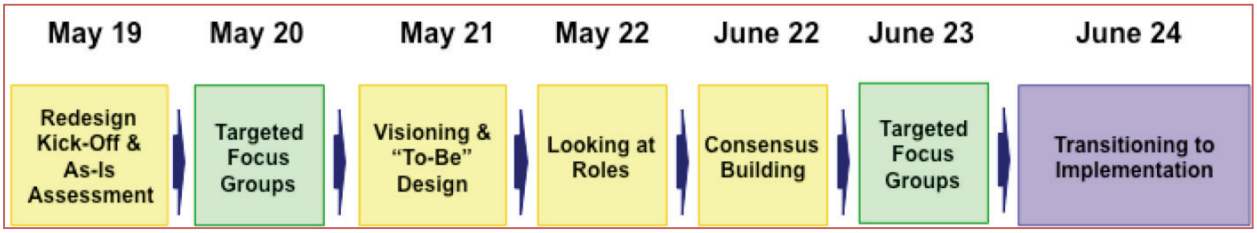
Faced with persistent and worsening shortages of many health care providers, a growing and unsustainable cost model and an aging population that will drive unprecedented demands for services, Government acknowledged that new models of care were needed - and needed now. To support creation of new models, the Department of Health took the bold step of looking at models across the continuum, because fixing models in any one sector would not address the One Island System mandate.

A cross-sectoral Design Team, consisting of more than 80 members was appointed and embarked on a rapid design process. The rapid design process was based on three underlying assumptions:

- **Rapid Design:** The Design model called for 5 design sessions and these were scheduled in two large blocks of time – one in May and a follow-up session in June 2009.
- **Inter-professional Design Team Approach:** The collaborative design process was grounded in strong input from a redesign team that reflected the diversity and needs of the full continuum of care that, collectively serves the population on PEI. Providers came from all sectors, included virtually every profession, and reflected all layers of staff from senior executives to front line providers.
- **Additional Input Sought from Stakeholders:** The redesign process included interviews and focus groups with staff and stakeholders from across the Island to allow them to participate in identifying key issues and opportunities to improve the patient and provider experience.

In total, more than 400 Islanders participated in the design, providing more than 4,000 person hours in the process. Throughout the process, the Design Team participants, stakeholders and other staff demonstrated a consistent and strong commitment to contributing to a renewed model of care that will improve care for Islanders, while creating better working environments for providers of care. The ultimate conclusion from the process is that the existing models are not working and new ways of delivering care are possible and necessary.

The calendar for design was as follows:



In addition to the design sessions and focus groups, a parallel planning session was completed with Home Care staff on June 19th. That session focused on opportunities to improve alignment between planning for expansion/enhancement of home care services with the emerging model of care discussions.

The first design session (May 19th) focused on the identifying and understanding issues and challenges impacting safe, efficient, high quality care delivery. A high degree of consensus emerged that the system was not centred around 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.

The second session (May 21st) shifted focus to the vision of a new model of care. Grounded in the overall vision for the system at large, the Design Team participants flagged a number of important concepts for the future model of care including: truly patient and family focused care; improved access to care, regardless of where people live; more consistency of services across the province; better coordination of care within and across sectors; and reduced barriers to flow between sectors so that people can get the care they need, where and when they need it.

Session 3 (May 22nd) started the process of looking at specific roles and how work may change both within individual jobs and in sectors. Emerging consensus from this session centred around enabling professionals to do the work that only they can do, and allowing others to do some of the work that is currently done by the highest trained people within any professional group. This led to a discussion of new roles that could be considered, as well as work that could appropriately and safely be done by the patient themselves or their family members. Some of the discussion also focused on work that could and should be supported and delivered in alternate settings such as primary care offices.

Session 4 and 5 (June 22nd and 24th) focused on confirming areas of consensus and testing some of the concepts from sessions 1 to 3. This is where the model – at least at a conceptual level – began to be confirmed.

The balance of this report defines the emerging model.

3.0 REVIEWING THE NEED FOR CHANGE

The CSI report that was released in November 2008 outlined in detail the reasons for change and the details will not be repeated here, but a summary of some of the major drivers include:

- Demand will grow to unprecedented levels as the population continues to age and the proportion of the people above the age of 65 trends towards 20% of the total populations.
- Human Resources shortages will continue as baby boomers prepare to exit the workforce in numbers never before experienced.
- The fact that health care costs routinely and consistently outpace the growth in provincial revenues will force fundamental changes.
- A growing sense of consumerism in the general public will demand that the system be more responsive.
- Staff must be allowed to work to their full scopes of practice and must be supported to deliver care differently.

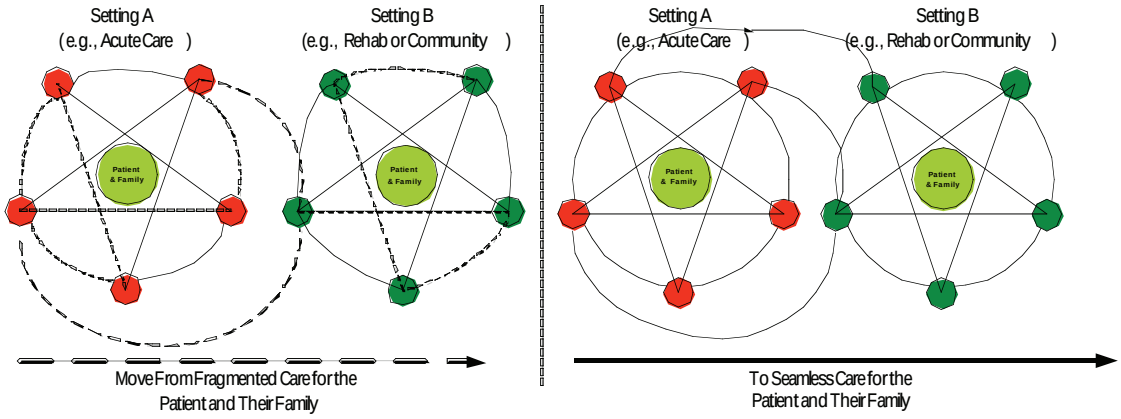
A thought from the global stage . . .

"We have to rediscover and re-ignite the idealism which first brought us to medicine, nursing and the NHS – our desire to make sick people better. We have to put our patients at the centre of our policies and practice, and to review – constantly, and in concert with colleagues and the communities we serve – how well we are working together to give our patients safe, excellent care.

We have to re-engage across our professional boundaries and unite in a deep, purposeful sense of ownership of our patients' welfare – an ownership that is both common to us all, and personal to each of us. And in this spirit of collective and individual responsibility, we have to face up to present weaknesses in the way we deliver safe, high-quality care – and respond with commitment, on behalf of those committed to our care, even if it involves taking risks or challenging convention and established opinion".

Moving beyond general sustainability issues and drivers for change, a core issue for Model of Care is the need for inter-professional care delivery models and processes. Inter-professional care is defined as "the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings"[1]. The expected benefits include: increased access to care, improved outcomes for patients, less tension and conflict among caregivers, better use of clinical resources, easier recruitment of caregivers, and lower rates of staff turnover.

The HealthForceOntario report that is referenced above identifies that our current system often separates caregivers rather than uniting them. As a result, there is little or no collaboration on patient care between caregivers, within or between settings. The report further goes on to define the need for regular and frequent dialogue between all health caregivers, within and between settings as necessary. All health caregivers must see themselves as part of the patient's care team. **This is a core principle for the emerging Model of Care in PEI.**



[1] HealthForceOntario, Inter-Professional Care: A Blueprint for Action, Toronto, July 2007

4.0 A Future Vision for Care Delivery

The first two design sessions were held on May 19th and 21st and were structured to confirm (a) if participants on the Design Team agreed that change was required and (b) if they held a similar view of what the future care team could and should look like.

Guiding Vision

All of the design work was guided by the Vision as outlined in the CSI Report which stated

In the future, care will be delivered through:

- A **single, integrated system of care**;
- One grounded **in evidence-based decision making;**
- Focused on **improving health and 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 result will be:

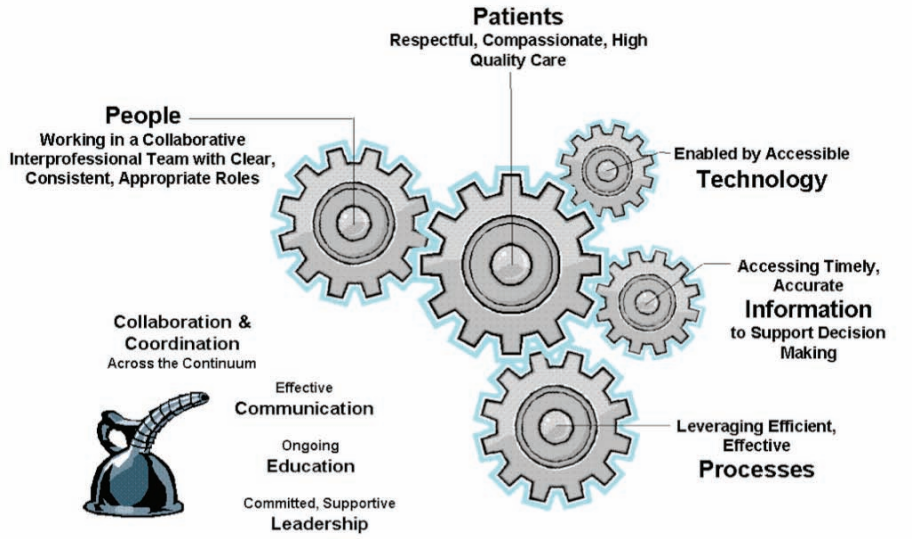
- A system that ensures Islanders **get the services they need and need the services they get;**
- A system that is more **safe, responsive and timely**;
- A system that **meets the needs of all Islanders** equitably;
- A system that **uses its resources as effectively as possible**; and
- A system that is sustainable and here to **meet the needs of future generations of Islanders**.

A Framework for Discussion

Using a redesign framework provided by CSI, the team was able to focus its discussions on change to reflect four ***key change levers***: People, Processes, Information and Technology. The four levers – or cogs as shown in the diagram below – are fundamental to many redesign efforts. For a new design to be better than the current state, the four cogs each turn in unison, with complete precision, to ensure a patient gets the right care. If one cog turns too fast or too slow, care will be interrupted.

Facilitating the cogs to turn involves a ***series of enablers:*** A commitment to collaboration and coordination; effective communication, ongoing education and strong and effective leadership. These enablers essentially serve as the lubricant or oil that ensures that the cogs of the new design work properly and stay aligned as the organization proceeds through implementation and testing of the new model.

At the centre of the new model is the Patient and all decisions about change must be grounded first and foremost in how it will improve care to the population as a whole.



WHAT WOULD THE TEAM CHANGE?

Using the above framework, the Design Team discussions flagged a number of issues that should be considered for change. These are outlined in the table below:

People	Process
The Design Team concluded that the concept of the care team is currently not well defined, particularly as it relates to delivering care to patients across the continuum. This led to a conclusion that clarity is required surrounding roles (i.e. who does what, when does it get done) Emerging HR issues and shortages were acknowledged as barriers to change as was the need for people to "let go" and be willing to trust that a new model, complete with new roles, will work.	The Design Team identified a number of processes that need to be changed if any new model is going to be effective including: integrated plans of care, discharge planning, medication administration, patient navigation, care coordination within the team, care management across the continuum – formal and informal. Standardization of these processes across PEI is viewed as a critical issue. The need to involve patients and their families more directly in their own care was also seen as an important principle for the new model.
Information	**Technology**
Information is currently viewed as a serious "dis-enabler" of integrated care delivery. Information flow is described as fragmented both within and across sectors along the continuum. Notwithstanding the significant investments that have been made in clinical information systems, the Design Team notes that it has not yet been rolled out in all sectors and information does not flow between providers in an effective manner. As a result, providers repeat questions, collect information using a variety of different tools and communication to support care delivery is hindered. Current documentation and information processes must be improved.	Technology issues can be both "low" and "high" tech. Low tech means issues related to basic equipment and technology to enable staff to do their jobs and ensure that patients get what they need. This can be as simple as equipment that is available and in good working order (e.g. adequate numbers of wheelchairs, stretchers, blood pressure cuffs) and can be more complex (e.g. ceiling lifts in patient rooms, equipment in patient's homes). High tech solutions include the investments already made in Information Systems as well as new communication tools for providers and web-enabled solutions for families to access information online. They can also include new diagnostic modalities and robotic investments.

All of the issues noted in the table above, as well as multiple other issues that were flagged during the rich discussions completed at the initial design sessions, emerged as a growing consensus that current service delivery models can be improved. That is not to say that all is bad – in fact, it is a clear testament to the strength of the people working in the system that care gets delivered every day to the people of PEI. Quite simply, staff make the system work, despite some of the underlying flaws in the service delivery models. That being said, it is also clear that the system can be improved.

The impact of all of the above on service delivery is described as follows:

- Services are not available when and where they are needed. The current system is too "hospital-centric".
- There is a lack of consistency in planning and delivery of care across and within the continuum.
- Care standards, planning and management are not formalized, and therefore are carried out in an ad hoc manner. The result is breakdowns in communication and coordination, leading to sup-optimal care.
- Missed Care is a reality due to a lack of time to complete care. Care providers need more time to focus on patient needs rather than being task oriented.
- Simply put - "We are not patient first. We are me first".

An Emerging Vision of the Care Model and Team

One of the techniques used to support the Design Team called for groups to draw pictures of the current and future model. These pictures typically serve as analogies of the changes envisioned. When drawing pictures of the current system, one group depicted the current system as a giant pinball machine, with the patient as the ball. Another described the system as a slot machine where the patient gets to pull the handle, but the result is random.

When asked to shift to drawing pictures of the new model, a set of more positive images emerged. One group described the system as a highway model where the highway itself reflects life and the goal is to keep the patient on the highway. Off ramps are designed to enable access to required services, but the goal is always to get back on the highway. Another group described the system as a large home, where services were convenient and accessible. Acute care was represented in this drawing as the garage, a place where you don't spend a lot of time.

Building on these images and leveraging the people, process, information and technology model described previously, this started to describe a consistent and clear vision of the future health care delivery model. Descriptors of this new vision include:

- Patients and Families must be at the centre of care and respected as a part of the care team and be better equipped to manage their own care;
- Care will be centred around the patient and not the hospital. As a result, community based services will take on a larger role, and tools to enhance relationships will be established;
- Each provider's role will be very clear, and how roles work together well defined. Trust will be a foundation of a newly defined team philosophy for care;
- All providers will work to full scope of practice;
- Unlicensed providers will be integrated more fully into the care environment;
- Access and flow into and through the system will be managed and coordinated seamlessly. Effective transitions will be a key element of the new model;
- A culture of wellness will be supported – this means, we try to keep a patient out of the hospital, and get them back home as soon as possible. Hospitals will no longer be a destination;
- Appropriate information will be easily accessible by providers and patients enhancing accountability;
- Access to services will be more appropriately available in the community to reduce pressures on hospitals and enhance timely access;

- Communication will be pivotal – however, communication extends well beyond the typical institutional model, and links in community, homecare, long term care;
- All sectors will be linked together using technology, processes, and information. This will provide a "provincial network" that ensures patients receive the care they need, when they need it (e.g., technology linking hospitals to homecare to schedule appropriate resources);
- Health promotion must be a key focus and receive necessary investments;
- Home care will play a more significant role within acute care through enhanced/understood linkages;
- All providers and patients will be supported through education tools to ensure they are ready and able;
- Innovative technologies will be used to support care of patients with chronic diseases (e.g., remote diabetes monitoring and consultation);
- Telehealth will be used to link patients to providers within PEI or outside of PEI. We will not try to build capacity where we have too little critical mass;
- Innovative staffing approaches will be utilized to ensure services are around the patient when they are required, and not on the predominant model in place today (i.e. Monday to Friday from 0900 – 1700 hours);
- Necessary technologies will be available at point of care;
- New strategies related to incentives should be developed to ensure system remains fair and equitable (e.g. can money follow the patient?); and
- All current delivery sites will take on new roles, shifting away from traditional definitions and services (e.g. adult day care, drop-in centres).

POTENTIAL CHANGES TO ROLES

Fundamental to Model of Care is the impact that any changes will have on roles that people currently play. As noted in the vision descriptors above, some common principles related to roles clearly emerged in the design process. These include:

- Each provider's role will be very clear, and how roles work together well defined. Trust will be a foundation of a newly defined team philosophy for care.
- All providers will work to full scope of practice.
- Unlicensed providers will be integrated more fully into the care environment.
- Innovative staffing approaches will be utilized to ensure services are around the patient when they are required and not on the predominant model in place today (i.e. Monday to Friday from 0900 – 1700 hours).

While much more work is required to confirm specific roles changes, some of the potential changes raised by the team include:

- **Nursing:** Nursing care roles will be redesigned to leverage professional/licensed staff more directly in core processes related to care planning, management and coordination as well as patient/family teaching and ongoing reassessments of a patients progress. To do this, staff will need some of their time freed up to enable them to focus effectively on the new priorities. Some tasks such as ambulation, supporting activities of daily living (e.g. bathing, feeding, bowel routines), monitoring of vital signs, completing accu checks, routine housekeeping, portering and general clerical duties all need to be built more consistently into other roles. This could mean changes to a number of roles such as the Nurse Manager, RN, LPN, RCW, Home Support Workers, Unit Clerks, Porters, Housekeepers, etc.
- **Allied Health:** As is the case with nursing, the Design Team concluded that current models do not leverage staff within the health disciplines as effectively as possible. Within individual professions, staff report that they routinely do not have time to complete adequate assessments, define individualized care plans and support specialized care delivery. Time wasters include clerical work, inappropriate screening of referrals, supporting routine care delivery that could be done by others and equipment preparation and cleaning. Work that was

identified as possibly being able to be transferred to other members of the care team includes: general ambulation and exercise; routine therapeutic interventions, accessing funding sources in the community and general administrative or clerical tasks.

- **Primary Heath Care / Community Based Care:** This group found that there was significant potential to leverage Primary Health Care Providers quite differently, both in terms of what they are asked to do and the settings within which they may do it. For example, they started the discussions by looking at primary care providers but quickly expanded it to consider how public health, home care and other community-based resources could be leveraged and integrated more effectively. One option debated was the concept of having people work under "one roof" (e.g. community health clinics). There was also consensus on the need for models to be more team-based and to allow alternate care providers (e.g. Nurse Practitioners) take on more roles (e.g. staffing urgent care centres).

In addition to the work of the Design Team, parallel work was being completed with **home care** staff from across the province who attended a meeting on June 19th to consider how their planning could align with the discussions at the Model of Care Design Team tables. A key point of alignment surrounded the sense that home and community would be more active drivers of care planning and coordination, a clear shift from the current hospital-centric model. This discussion was similar to the primary care break-out group that conceptualized a model whereby navigation or coordination would be based in the community and enabled by local providers.

In this new model, home and community based providers – ranging from the patient themselves to primary care providers to staff who work in home and community based care environments – will accept increased responsibility for care planning and coordination of the care and will generally enable entire populations of patients (e.g. frail elderly) to better navigate the health care system. To do that, models will need to be built around four themes:

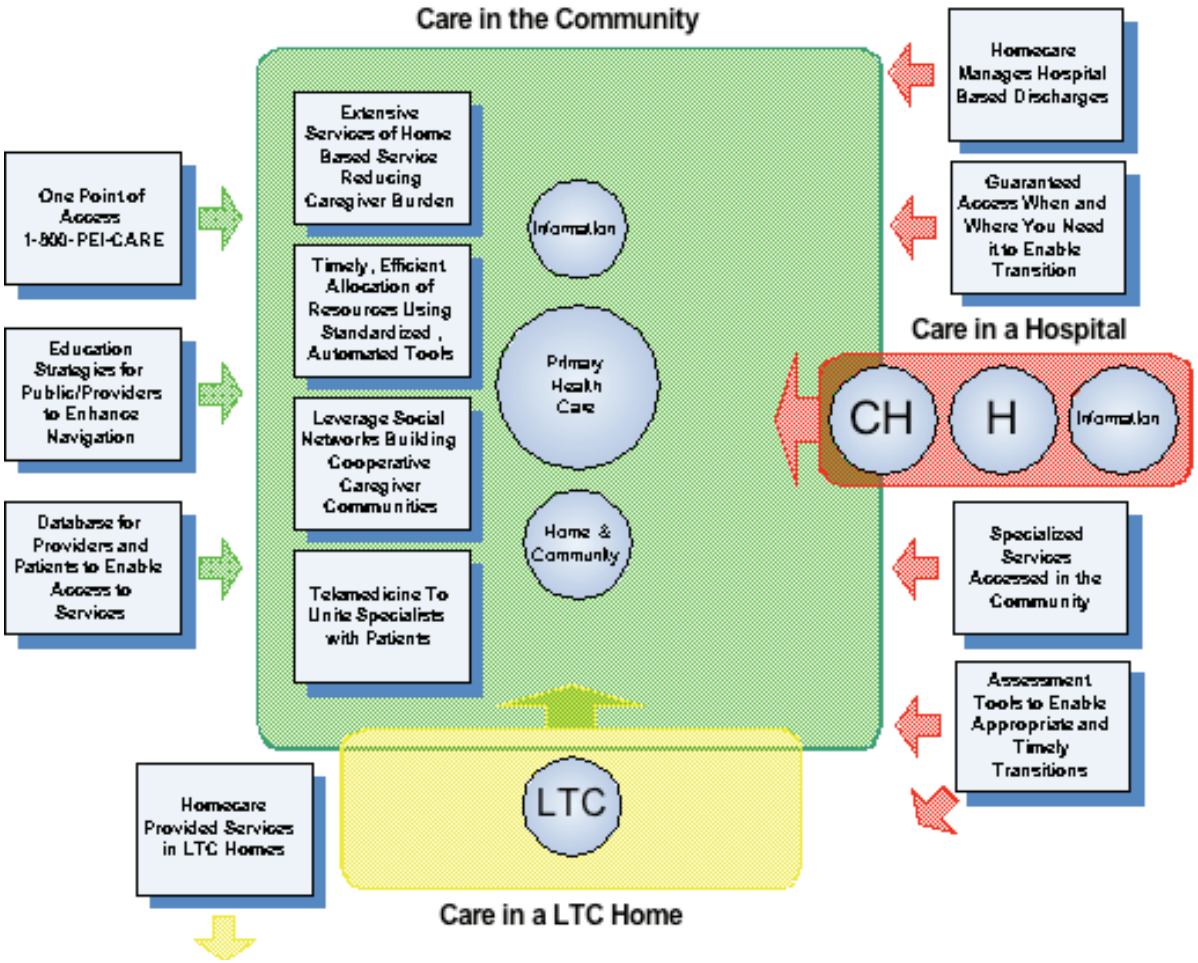
- **Enabling Efficient and Effective Intake & Coordination.** This included a number of potential concepts and themes, including:
    - A single point of access for information to help enable self-care and system navigation (e.g. 1-800-PEI-CARE)
    - Education Strategy for the Public and Providers to Enhance Navigation (Paper-based and electronic tools to raise awareness)
    - Database for Provider and Patients to Enable Effective Navigation and Coordination (Continuum based services helping people to know where services are available)
    - Developing a Comprehensive Service Plan for Each Patient where the Community Case Manager will develop a Service Plan WITH EACH client and this will include ALL services required to meet their needs – no only services provided and paid for by home care
- **Coordinating Home and Community Services Using New Models and Tools.** This included the following:
    - Full Bucket of Home Based Services Enabling Transitions to Help Caregivers to Reduce Burden such as caregiver support and services that can be easily accessed (e.g., Meals-on-Wheels, friendly visiting, transportation, attendant care)
    - Leverage a Social Network To Design Cooperative Communities of Caregivers by Revitalizing Spirit of Helping Each Other (e.g. use volunteers, cost share)
    - Timely and Efficient Allocation of Resources including automated tools to identify most appropriate, accessible resources
    - Telemedicine to Unite Specialists with Patients to ensure appropriate utilization of scarce resources, use telemedicine (e.g., nutritionist, wound management, chronic disease management)
- **Innovatively Transitioning Services from Hospital to Care in the Community.** This includes a significant shift in foci to a system that is driven by home and community service structures and processes:
    - Community-Based Providers Manage All Discharge Planning which will require a total "rethink" re: the type of people who support discharge planning and management by

leveraging a pull methodology with caregivers who understand the continuum of care landscape

- Guaranteed Access When and Where you Need it to Enable Transition (Develop Urgent Blocks that can be directly scheduled into)
- Specialized Services Accessed in the Community (e.g. Community IV, Wound Protocols – Provide locally or buy from others)

- **Enhancing Service Delivery Models within Long Term Care.** This essentially means having home care services available within LTC settings so residents can have their additional care requirements met at home as opposed to being transferred to hospital:
  - Provide services not available in settings (e.g., PT, OT, Speech)
  - Create new programming options (adult day care)
  - Leverage linkages with Primary Health Care (e.g. physician clinics in new settings, assessment clinics)

One option for a model that grounds more responsibility in the home and community is depicted below.



5.0 SUMMARIZING CONSENSUS

The design process culminated in the 5th meeting with the consultants playing back a "working model" for how the caregivers will deliver care to patients and their families in the future. While there was some debate about the level of consensus that existed, this appeared to be primarily grounded in an acknowledgement that key aspects of the model still required detailed planning to be complete. Notwithstanding this caveat, the working model is as follows:

- People are enabled to provide more of their own care for themselves;
- When support is needed, the goal is to keep the person in their own homes for as long as possible, leveraging supports in the local community as needed;
- Access to services will be streamlined through the use of consistent tools and processes;
- Telemedicine will be used more extensively to enable care planning, conferencing, interventions and follow-up;
- Community based providers will drive coordination, with additional resources being provided as the complexity of coordination increases;
- Services within local communities will be enhanced as appropriate and as is consistent with the goals of high quality, sustainable and affordable patient care delivery; and
- When people need to travel to access services, these too will be coordinated and focused on enabling access and timely return to their home community for follow-up care as required.

Using the People, Process, Information and Technology lens, the key attributes of this model are:

People:

Patients and Families will be at the Centre of Care and as such, all care planning, coordination and delivery will be grounded in what is best for the patient and their family and these decisions, to the extent possible based on individual capacity, will be made by them. The role of the patient in the care team should also be expected to deliver some parts of their own care, such as administering some medications, as they would outside of the hospital.

Care will be structured around populations of patients, be that the patients in a community-based clinic, long-term care homes, acute care hospitals or in the patients own home. Teams will be deployed to meet the needs of the defined populations and will range in size depending on the needs and number of people being served, and the partnerships required to fully meet those needs.

Care will leverage an inter-professional care model, where all providers work to their defined scopes of practice. Under the emerging model, every team member will work to his or her full scope of practice in a clearly defined role. A model was presented on the last day that suggests that teams will include four different types of providers, including both professionals or licenced staff and unlicenced personnel:

- The "24/7" team – those members who must be present with the patient 24 hours a day, seven days a week to provide some aspect of care. Note: in some cases this will be the family or other "informal" caregivers.
- The "7 day a week" team – those members that predictably participate in care delivery seven days a week but are not required to be present with the patient 24/7. Note: this team may include people who are on-call, but not in-house or present with the patient at all times.
- The "consulting" team – those members that are available on an as-needed basis but generally not interact with the patient everyday. These members of the team will interact with varying levels of frequency or intensity.
- The "support services" team – those members who have critical roles to play in delivering services, but may not interact directly with the patient.

Teams will be grounded in mutual trust and respect for each member of the team, will understand each others roles and scopes of practice and will contribute both individually and collectively to the development of integrated care plans in accordance with those scopes of practice. Leveraging various

members of the team more effectively will be a core requirement, as will the need to consider how unlicenced care providers will be more consistently and effectively utilized to support care delivery when appropriate.

Care planning and navigation will become the responsibility of a community based care coordinator:

- Either by the patient themselves (self care), or
- Through the efforts of the Primary Care Provider, or
- By an assigned home & community care coordinator.

The conceptual model reviewed suggests a tiered response model whereby additional resources would be called in to support coordination as required. The home and community providers would have overall responsibility for coordinating care and supporting navigation across the continuum. Coordination within care sectors would continue to be done by staff within the applicable setting.

Processes:

Building on the conceptual model that leverages coordinators within and across sectors, care coordination is also a major focus of the process changes that will ultimately need to be implemented. Core processes such as care planning, coordination, communication, discharge management, will all need to be restructured to enable change.

As a starting point, the Design Team discussed models from other jurisdictions to provide examples of structures relative to similar populations of patients. For these population groups, the concept of enabling transitions becomes a major focus, with an overall goal of ensuring ease of access across

the system and within individual care delivery sites. Within this context, intake and assessment processes must be a priority.

Moving beyond improved care planning, coordination and management, team functioning, team dynamics and renewed decision making models that reflect a team model all need to be designed and deployed. One option to consider will be new models for inter-professional rounds and case conferencing as well as new communication processes.

Information and Technology:

Appropriate information will be easily accessible by providers and patients enhancing accountability. To achieve this, all sectors will be linked together using technology, processes, and information. This will provide a "provincial network" that ensures patients receive the care they need, when they need it (e.g., technology linking hospitals to homecare to schedule appropriate resources).

Patients, families, public health providers and other professional providers will have improved access to informational resources through a mix of modalities including user information guides, web-based tools and ideally, a 1-800 line that connects people to resources.

The Design Team also encourages government to pursue a nurse call-in line, possibly combined with a resource line. PEI is the last province in Canada to adopt such a model.

Basic equipment requirements should be reviewed, firstly on showcase units, and then on a larger scale. Plans should be developed and "low tech" solutions should be implemented as resources become available.

Other potential solutions described include:

- Telehealth and video conferencing will be explored to enable care
- Automated solutions will be fast tracked where possible (e.g. Inter-RAI)
- Cerner will be leveraged further
- Innovative technologies will be used to support care of patients with chronic diseases (e.g., remote diabetes monitoring and consultation)

6.0 TRANSLATING CONCEPTS INTO REALITY

The challenge for the Model of Care Leadership Team is to now take the conceptual design created by the Design Team and translate it into practical working models within the individual sectors, while linking the sectors across the broader continuum. The following list provides some examples as to how this may look within an individual setting.

Note: the information presented here does not reflect specific models or details that were agreed to by the Design Team. Rather they reflect concepts that began to emerge at the design session and have been encapsulated by the consultants to support future discussion and implementation.

Care at Home:

The care team surrounding patients at home will start with the family or other informal caregivers who provide the majority of the 24/7 care to meet a persons individual needs. Support for the informal caregivers will come in many forms, depending on the needs and could include primary care physicians, other primary care providers, volunteer supports and supports from community-based agencies. It could also include formal interventions with home care staff and other ambulatory care that the patient would travel to receive.

On the surface, this may not seem that different from the model today, but in the new model, specific differences will include:

- Informal caregivers will have access to information and resources that is not currently available.
- Primary care providers will also have access to additional information to support them in fulfilling their initial care coordination, diagnostician, and treatment delivery responsibilities.
- Home care will offer a broader range and depth of services, including additional services to support remaining at home, access to services in extended hours (both evenings and weekends), new intake processes that streamline and fast-track access and enhanced linkages with other sectors when and as needed.
- More services will be available "locally", which means that additional ambulatory care supports designed to support people living at home longer will be available within community hospitals, family health centres and in new environments such as manors, nursing homes and community care facilities.

Care in a Primary Health Care Setting:

While the original list of showcase units (i.e. the units that will be the initial sites for implementation) does not formally include a primary health care setting, discussions at the Design Team meetings raised this area as an important enabler of the new model. In those discussions, it was noted that service expectations need to be clarified to ensure that primary care physicians are supported in delivering the essential services required to enable access, while also leveraging other roles (e.g. Nurse Practitioners, Family Practice Community Nurses, LPNs, unlicenced providers and potential new roles such as Physician Assistants, to deliver aspects of primary care.

Care in a Long Term Care Setting:

Care team models differ throughout the various LTC settings, with some differences grounded in regulations (e.g. barriers to allow LPNs to work at full scope in community facilities) and others in historical differences in funding levels and skill mix ratios. The discussions at the Design Team called for more consistency and removal of barriers that prevent the private sector partners from leveraging staff as described in the conceptual principles. This area likely requires formal discussion to clarify how needs will be assessed and resourcing levels defined to support the case mix expected within different settings.

Care in Community Hospitals:

The focus of care at community hospitals will continue to evolve and include enhanced models to support local care delivery (as described in the care at home section immediately above). Some

community-based service providers may have their offices located within the hospitals and additional services will be co-located into the hospital facility to create a larger hub of services at the local hospital. Note: In communities where there is no local community hospital, similar models may emerge in settings such as nursing homes, manors and primary care centres.

Ambulatory services delivered in these settings will leverage a care team grounded in the principles that were defined within the Design Team process which means that they could reflect models that extend some services into evenings and weekends, leverage staff at the full scope of their licensure and integrates both existing and new roles as appropriate.

For inpatient services, the care team will reflect the needs of the population that is expected to be served and will include (as appropriate) RNs, LPNs, Care Aides, Allied Health professionals, support services and family members. Existing models will shift as required to ensure that staff are aligned with the acuity if the patients. The Design Team also discussed the need for inpatient services to be leveraged to support flow which could include the identification of transitional, convalescent and restorative care models at community hospitals, all of which will be focused in enabling discharge from the Acute Care Hospitals in Charlottetown and Summerside.

Care in Acute Care Hospitals (QEH and PCH):

The discussion on care models at the Acute Care Hospitals is grounded in a vision that is more focused on episodic interventions with discharge back to the home or community-based care setting being viewed as a key goal for the majority of patients. This will require structured models that embed care coordination processes to enable the smooth transition and flow of care for populations of patients (either the patients on a unit or a pod within a unit). Staff will work in "team based models" that reflect a blend of 24/7 providers working in an integrated fashion with other staff who engage with the patient in two models: (1) those providers that will be involved in a 7 day a week model but not consistently on the unit and are present on a 24 hour basis, and (2) staff who function more in a consulting model and engage with the patient as needed but not everyday. These models will fundamentally change current processes and working relationships between nursing, physicians and allied health providers and have the added complexity of being able to respond to and balance admissions for both scheduled and unscheduled patients.

In addition to episodic response model, both QEH and PCH will need to develop service models similar to those proposed for the Community Hospitals including transitional, convalescent and restorative care units that cluster these patients into pods that allow for the proper care milieu to be created and staffed with new model that leverage different skill mixes and ratios of patients per provider.

Issues to consider:

A number of key issues came up during the Design Team deliberations that need to be considered as these new models are implemented:

1. The need to support management and leadership at the unit level;
2. The need for team building and change management strategies to be in place to reduce stress associated with the move to new models;
3. The need for some high priority processes to be redesigned in parallel (e.g. care coordination, care planning and discharge management);
4. The need for access to more consistent information regarding the patient's needs across multiple care settings; and
5. The need for ongoing engagement with all stakeholders.

7.0 NEXT STEPS

To transition from a Model of Care "Plan" to the actual deployment and realization of benefits, a mobilization (Roll-Out) plan will be essential to ensure necessary planning, design, training, communicating, and overall preparation of all care providers across the continuum. To assist PEI in their planning, CSI has prepared a high-level, four phase plan to support the process. Key phases include:

Phase 1 – Endorsement of the Model of Care Design. This is a critical step to ensure provincial endorsement of the model. This includes approval from the Department of Health, with clear agreement for moving forward from each 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 – Building Teams to Support Roll-Out. This phase reflects an important pre-planning step to identify necessary resources and other critical success factors that must be present to begin. Some early considerations may be to ensure union support, project management and available expertise, engagement of regulatory bodies. To support this planning, temporary Implementation Support "Build" Working Groups will be identified, staffed, and organized to work on specific deployment areas of focus. Based on our experience, we suggest development of 6 Working Groups to identify and complete a defined set of tasks/deliverables to support deployment of the Model of Care, based on an approved timeline.

- **Education Implementation Support Working Group** provides overall direction for designing the education and development approach for staff on the showcase units and overseeing implementation to enable successful deployment of the Model of Care;
- **Change Management and Communication Implementation Support Working Group** provides overall direction and oversight for the development of change management and communication support and strategies for the implementation and evaluation of the model of care on showcase units;
- **Finance Implementation Support Working Group** provides overall direction and oversight to the financial management and measurement components of the new Model of Care;
- **Human Resource Implementation "Build" Working Group** provides overall direction and recommendations for the Human Resource components;
- **Process Design Implementation "Build" Working** provides overall direction and recommendations related to the process improvement and redesign needs for the successful implementation of the Model of Care;
- **Technology Integration Implementation Support Working Group** provides overall direction and recommendations for Model of Care related technology needs to enable ongoing coordination with other technology projects within PEI.

To support this work, a project manager should be assigned to provide guidance and oversight to the process.

Phase 3 – Performance and Evaluation Planning. The performance and evaluation phase reflects a critical need to clearly identify expected benefits and impact in advance of moving forward, and to identify supporting metrics. It is expected that the ongoing rollout of the Model of Care will be based on a successful rollout of the selected showcase units, hence documenting the benefits will be critical.

Phase 4 – Showcase Readiness. This phase is an important step to complete all necessary pre-work by Support "Build" Working Groups including job description changes, redesign efforts, technology alignment, education plans etc. Depending on the activities, the pre-implementation phase may vary however the phase must be condensed and managed so as not to draw out this phase. Each Working Group will work in coordination with other groups, under direction of the project manager.