Strategies for Transition Planning in Ontario's Local Health Integration Networks

Sue Vanderbent

Introduction

Health programs are largely funded and managed independently of one another.[1] Yet, healthcare consumers are dependent on these organizations to work together seamlessly across all organizations and levels of care in the healthcare system. With the introduction of Local Health Integration Networks (LHINs) in Ontario, it is essential to support and encourage healthcare providers to communicate with each other across complex organizational boundaries (Glouberman 2002). From the patient/client perspective, the LHINs will be successful when integration occurs at the point of care.

Changing demographics and patterns of healthcare use by healthcare consumers is creating a quiet revolution in the way care delivery is designed and in the way transition planning is managed across the continuum. In this article, the key quality processes of routine one-way discharge planning from acute care to primary and community care are expanded to examine the need for a new function within the healthcare system called, by the Ontario Home and Community Care Council (OHCCC),[2] "transition planning."

Transition Planning

Transition planning can be defined as the management of a complex "two way" interface between and among institutions and community-based service providers. Transition planning is particularly important for those persons of all ages who require ongoing system support due to longer-term or chronic mental or physical illness (Gilmartin 1994). Strong working relationships between providers and willingness to share timely and relevant information in all parts of the healthcare system are required to support good transition planning for people. Using theoretical constructs taken from routine one-way discharge planning, transition planning emphasizes the need for continuity and quality of information exchange between providers as people receive care, moving back and forth through the permeable boundaries of all parts of the healthcare system (Senge 1999).

Since structural changes alone will not lead necessarily to seamless care delivery, a results-based accountability system is needed to support and monitor the effects of transition planning by the LHINs. To support excellence in transition planning, we need to:

1. This includes community and public health, CCACs, home-care providers, mental health, acute/chronic/rehabilitation hospitals, pharmacies, laboratories, long-term care facilities and physician services.

2. The OHCCC comprises six associations that represent key providers in the delivery of home and community care health services in Ontario: Ontario Association of Community Care Access Centres (OACCAC); Ontario College of Family Physicians (OCFP); Ontario Community Support Association (OCSA); Ontario Home Care Association (OHCA); Ontario Pharmacists' Association (OPA); Ontario Federation of Community Mental Health and Addictions Programs (OFCMHAP). Formed in 2002, the OHCCC provides a forum to speak with one voice on policy, planning and programming issues to enhance service delivery. It also works with the Ontario Ministry of Health and Long-Term Care to stabilize and enhance the home and community care sector in the interests of the healthcare system as a whole. See www.ohccc.ca.

1. identify key system-wide quality process for information exchange
2. determine larger health system performance indicators and outcomes

Key Quality Processes

As the system moves from the treatment of the younger, episodically ill patients to the ongoing support of the frail elder, or persons of all ages with a lifelong medical or mental illness, a critical success factor in assuring quality is to identify and apply intersectoral key quality processes for transition planning. Key quality processes are activities that assist organizations in effectively meeting customer demands, and are the basic building blocks of communication between healthcare providers within the system (King 1994).[3] Once identified, these processes can be standardized across sectors to improve current practices.

Clear articulation of key quality processes in transition planning for people sheds new light on healthcare "system" performance outcome indicators, such as overall decreased unplanned readmissions to acute care for both mental and physical health reasons. Tracking the movement of specific, identifiable subpopulations of clients (e.g., persons with chronic obstructive pulmonary disease [COPD]) may be a useful place to begin to understand how the system can be improved to give more coordinated care (Andren and Rosenquist 1987).

System Performance Improvement

Once specific system performance outcome indicators related to improved communication are identified, data about current system practice can be measured and baseline levels of system function set. When current baseline data is in place, the stage will be set to identify measurable time targets for system performance improvement. Each healthcare provider in the LHIN can play an important part in supporting new system performance indicators that are collectively, not individually, shared and managed. Annual reporting in a balanced scorecard format would showcase the success of each LHIN as it moves toward the achievement of a truly integrated "system of care" for people at the local level.

Key Quality Processes of Care Transitions

Transitions from Community Care to Emergency Care

Are there processes in emergency:

- to identify persons at high risk for transition planning needs?
- to include patient, family and caregivers in the gathering of relevant medical and social history that will affect transition?
- to notify the family physician regarding the emergency presentation of a person requiring transition planning and request appropriate information?
- to involve appropriate multidisciplinary staff necessary for the identification of complex transition issues?
- to transfer relevant information about the medical care and the supports being provided in community to emergency staff?
- to ensure that relevant information is obtained from the community healthcare providers in a timely fashion?
- to ensure that emergency staff are asked for input regarding their satisfaction with the transfer process by key stakeholders such as community healthcare providers and family physicians?
- to incorporate information from customer satisfaction surveys into an improved practice model?
- to evaluate the internal key quality processes with respect to improving the practice model?

Transitions from Acute Care to Community Care

Are there processes within acute care:

- to involve appropriate multidisciplinary staff, including social work, for the identification of complex transition planning needs?
- to notify and include family physician input and relevant community healthcare provider input into the admission process of the acute care setting?
- to ensure within the institution the timely transfer of relevant information concerning the transfer of the patient to the community?
- to set an anticipated date of acute care discharge, which is contingent on the admitting diagnosis established either prior to admission (elective surgery), at admission or within 48 hours of admission (for a minority of cases)?
- to communicate the anticipated date of acute care discharge to the patient, family, family physician, community healthcare providers and other relevant acute care staff?
- to involve the family and caregiver in all aspects of preparation for the transition back to the community, including their preferences and perspectives and values?
- to educate the patient and family about the healthcare system related to their care, the responsibilities of the healthcare providers in the transition process and contact information in the case of concern?
- within the acute care system to communicate in a timely and responsive way with the community healthcare providers, family physician and pharmacist (if required) to notify and involve them in the preparation of transition plans?
- to ensure the patient has access to the necessary/required supportive equipment (assistive devices, medical equipment

3. Quality efforts involve monitoring a process (communication) and systematically eliminating causes of unsatisfactory performance.

and supplies) prior to transition?
- to ensure that an acute care contact is available following transition to ensure continuity of the transfer process?
- to ensure that proper medications are available within the first 24 hours of transfer?
- to ensure that the relevant community healthcare providers (including the family physician) are asked for input regarding their satisfaction with the transition planning processes within the acute care sector?
- to ensure that healthcare consumers are asked for input regarding their satisfaction with the transition processes in the acute care sector?
- to incorporate information gleaned from all customer satisfaction surveys to improve upon current acute care transition planning practice?

Transitions within the Community Care System

Are there processes within the community:
- to include the client and family in the preparation for the transition, including acknowledgment of their perspectives, values and preferences?
- to include family physician input into the transfer process?
- to understand the information needs of the receiving caregivers and customize information exchange regarding the transition to meet the needs of these providers?
- to transfer the relevant and needed information regarding the care of the person?
- to ensure that the receiving caregivers are asked for input regarding their satisfaction with the transfer process of the sending caregiver?
- to ensure that clients, their family members and other informal caregivers are asked about their satisfaction regarding the transfer process?
- for the sending caregivers to receive feedback about customer satisfaction from receiving caregivers such as family physicians, pharmacists, long-term-care facilities and relevant community health providers?
- for sending caregivers to incorporate information gleaned from customer satisfaction surveys into an improved practice model?

Outcome Indicators for Improved Health System Function as a Result of Better Transition Planning

1. increased customer satisfaction with transition planning processes across the various sectors of health and social care (McWilliams 1993)
2. decreased unplanned readmission rates and/or fewer total days of hospitalization for specified target populations (Shulkin 1993)
3. reduction in rehospitalization rates and cumulative lengths of stay of certain types of persons with lifelong illnesses (Parfrey et al. 1994)
4. improved relationships between family physicians/community healthcare providers and hospitals leading to increased linkages and better care for persons (McWilliams 1993)
5. greater efficiency and quality in placement planning for persons requiring ongoing supportive living arrangements (Murphy 1997)
6. a reduction in the use of emergency services and broader social services such as police, the justice system and shelters for persons with for persons with mental health and addiction issues (Social Planning Research Council 2004)
7. total system cost reduction due to better and more efficient use of healthcare resources (Naylor 1994)

Conclusion

Identification of key quality processes related to transition planning and the development of system performance outcome indicators are critical to the development of a systems approach to care across the continuum. When every LHIN in Ontario can support successful transition planning, true integration will occur at the point of care. Successful management of this process can lead to greater efficiency, effectiveness and accountability for care as the system integration of healthcare in Ontario progresses. HQ

Authors' Note: The unedited version of this paper, which references the details related to key quality processes, can be found on the website of the Ontario Home and Community Care Council: www.ohccc.ca.

References

Andren, K,G. and U. Rosenquist. 1987. "Heavy Users of an Emergency Department – A Two Year Follow-Up Study." *Social Science &:Medicine* 25(7): 825–31.

Basinski, T. 1996. *Management of Acute Care Bed Resources in Ontario.* Toronto: CES.

Booth, J., and C. Davies. 1991. "Happy to Be Home? A Discharge Planning Package for Elderly People." *Professional Nurse* 6(6): 330–32.

Bryan, L. 1996. *A Design for the Future of Health Care.* Toronto: Key Porter Books.

Farren, E.A. 1991, January/February. "Effects of Early Discharge Planning on Length of Hospital Stay." *Nursing Economics* 9(1); 25-30

Gay, P. and J. Pitkeathly. 1979. *When I Went Home: A Study of Patients Discharged from Hospital.* London: Kings Fund.

Gilmartin, M.E. 1994. "Transition from the Intensive Care Unit to Home: Patient Selection and Discharge Planning."*Respiratory Care* 39(5): 456–80.

Glouberman, S. 2002, July. "Complicated and Complex Systems: What Would Successful Reform of Medicare Look Like?" *Discussion Paper No. 8,* Commission on the Future of Health Care in Canada.

Hollander, M. and N. Chappell. 2002. *Final Report of the National Evaluation of the Cost-Effectiveness of Home Care.* Health Transition Fund. Health Canada.

Jackson, M. 1990. "Use of Community Support Services by Elderly Patients Discharged from General Medical and Geriatric Medical

Wards." *Journal of Advanced Nursing* 15: 167–75.

Jewell, S.E. 1993. "Discovery of the Discharge Process: A Study of Patient Discharge from a Care Unity for Elderly People." *Journal of Advanced Nursing* 18: 1288–96.

King, B., 1994. "Techniques for Understanding the Customer." *Quality Management in Health Care* 2(2): 61–67.

Leatt, P., G.H. Pink and K. Naylor. 1996, March. "Integrated Delivery Systems: Has Their Time Come in Canada?" *Canadian Medical Association Journal* 154(6): 803–809

McWilliams, C.L. 1993, December. "Achieving the Transition from Hospital to Home: How Older Patients and Their Caregivers Experience the Discharge Process." Working Paper Series, Thames Valley Family Practice Research Unity, Paper #93-1.

Murphy, F., 1997. "Blocked Beds." *British Medial Journal* 1: 1395–96.

Naylor, N., D. Brooten, R. Jones, R. Lavisso-Mourey, M. Mezey and M. Pauly. 1994. "Comprehensive Discharge Planning for the Hospitalized Elderly." Agency for Health Care Policy and Research. US Department of Health and Human Services, Public Health Service.

Ontario. 2004. "Smart Systems for Health Agency." Retrieved May 8, 2005. <www.thinksmart.ca>.

Parfrey, P.S., E. Gardner, H. Vavasour, J. Harnett, C. McManamon, J. McDonald and J.Dawe. 1994. "The Feasibility and Efficacy of Early Discharge Planning Initiated by the Admitting Department in Two Acute Care Hospitals." *Clinical and Investigative Medicine* 17: . 88–96.

Roberts, I. 1975. *Discharged from Hospital*. London: Royal College of Nursing.

Saunders, J., 1996. *Regional Programs … The Concept and Planning Process.* Calgary Regional Health Authority.

Senge, P. 1999. *The Dance of Change.* Library of Congress.

Shepperd, S., J. Parkes, J. McClaran and C. Phillips. 2004. "Discharge Planning from Hospital to Home" (Cochrane Review). *In The Cochrane Library.* Issue 3. Chichester, UK: John Wiley and Sons.

Shulkin, D., B. Kinosian, J. Glick et al. 1993. "The Economic Impact of Infections." *Archives of Surgery* 128: 449–52.

Skeet, M. 1970. *Home From the Hospital.* Dan Mason Nursing Research Committee. Florence Nightingale Memorial Committee. London: Macmillan.

Social Planning and Research Council. 2004, August. "Progress Report on Homelessness in Hamilton, 2003." In *Where It Is Needed, When It Is Needed.* Discussion Paper, Ontario Federation of Community Mental Health and Addiction Programs.

Vydelingum, V. 1989. *The Discharge of Elderly Patients from Non-geriatric Wards.* Unpublished BSc dissertation, North-East Surrey College of Technology.

Wells, D.L., D.K. Martin, A. Moorhouse, D. Craig and J.M. Foley. 1999. "An Integrated Model of Discharge Planning for Acutely-Ill Elderly Patients." *Canadian Journal of Nursing Leadership* 12(3): 6-12.

Zwicker, D. and G. Picariello. 2003. "Discharge Planning for the Older Adult." In M. Mezey, T. Fulmer, I. Abraham and D.A. Zwicker, eds., *Geriatric Nursing Protocols for Best Practice* (2nd ed., pp. 292–316). New York: Springer Publishing Company.

About the Author

Sue VanderBent, BA, BSW, MSW, MHSc, CHE is Chair, Ontario Home and Community Care Council and Executive Director of the Ontario Home Care Association. Sue is a member of the Faculty of Health Sciences at McMaster University. She can be reached at the Ontario Home Care Association, 19 Melrose Avenue South, Hamilton, Ontario L8M 2Y4; Phone: 905 543-9474; Email: suevan@homecareontario.ca

The author wishes to acknowledge the Hamilton-Wentworth Regional Discharge Planning Working Group (1997) for their constructive remarks regarding key quality processes and indicators for successful discharge/transition planning.

COMMENTARY

Creating Permeable Boundaries

Carol Slauenwhite and Marg McAlister

Ms. Vanderbent points out that transition planning is important to effective patient care. While the transformation to LHINs in Ontario provides a means for dramatic change, her description of the "key quality processes of care transitions" is relevant in any setting. Ms. Vanderbent reminds us to look at the detail in client care and to turn ourselves to accommodate the client as we, the healthcare providers, operate within our system.

Clients are not excellent historians and often, because what happens in the hospital is profound, that occurrence will be remembered, and the critical details of the majority of the healthcare experience – the community – will be largely forgotten or misreported. Focusing on transitional needs and planning to improve the bridge from one service to another is critical to reducing duplication and improving outcomes both at an individual and at a systems level.

In its work to improve the handoffs within healthcare, the Calgary Health Region has broadened the scope of home care with compelling results. The Regional Home Care program's case managers, known as Community Care Coordinators (CCC), have expanded their scope from traditional case management of clients ("client" always refers to the family network, as well as the identified person in the program) who require "in home" support and professional services to a broader role of supporting family physicians in their practices.

The CCCs now partner with these doctors to provide support and monitoring of clients that have a chronic condition but as yet do not require traditional in-home support – known in the Home Care Program as "External Chronic Disease" (ECD) clients. The CCC supports and arranges care for ECD clients based on disease algorithms approved by key stakeholders within the Region. Having the input of the broader healthcare team ensures that the approach to care and relevant indicators are agreed to and facilitates consistency. A better understanding of the contribution of the various components of the healthcare system as a result facilitates smoother transitions.

The chronic disease algorithms are supported by a chronic disease management information system (CDMIS) accessible to CCCs and an increasing number of key stakeholders. If ECD clients use acute care, the CCC is notified and will capture the event in the CDMIS database alerting and enabling access to the relevant information by the health team.[1]

Timely access to information and an expanded role for home care triggers better planning. For instance, if the client with diabetes has an abnormal A1C, the CCC, in the expanded capacity, will determine whether the client should be seen in the "Diabetes, Hypertension, Cholesterol Clinic" for one-to-one counselling; in the "Living Well Program" for group education, exercise and self-management classes; or by the family physician and the CCC for clinical care. If the client is too frail to travel, or is not appropriate for group classes, the CCC can arrange for resources to be available at the physician's office at the next appointment or make a home visit.

The significant improvements being achieved for clients keep the team working together and trying to determine when and where the client, will be best served. Accommodating the client and not our structure, is working. This model of care is creating permeable boundaries, which allow strong working relationships to evolve, thus supporting clinicians in the provision of seamless care to clients. HQ

1. Our involvement in the National Partnership Project funded by Health Canada's Primary Health Care Transition Fund and sponsored by the Canadian Home Care Association is enabling physician access to CDMIS. For more information on the Project, visit www.cdnhomecare.ca/primary.

About the Authors

Carol Slauenwhite RN, MN, is a Primary Care Specialist based in Calgary, AB. She graduated from Sault Ste. Marie with RN diploma and later the University of Calgary with undergraduate and graduate degree in Family Systems Nursing.

Marg McAlister is a nurse by profession with experience in both the acute care and home-care environments. Currently she is the Project Manager for the Canadian Home Care's National Home Care and Primary Health Care Partnership Project funded by Health Canada.

The Ontario Hospital Association (OHA) will present a therapeutic Clown workshop in October.
For more information
contact: clown@longwoods.com