

# TRANSITION

## PLANNING in

# HEALTH CARE SYSTEMS

## Key Quality Processes and Outcome Measures

A DISCUSSION PAPER

THE ONTARIO HOME & COMMUNITY CARE COUNCIL

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# EXECUTIVE SUMMARY

The introduction of Local Health Integration Networks (LHINs) is the first major step in the creation of a truly integrated healthcare system in Ontario. From the patient/clients perspective, the LHINs will be successful when integration occurs at the point of care. 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 transition planning, we need to:

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

There are very few, if any, areas of Ontario where system-wide key quality processes related to transition planning or system performance outcomes are being tracked or reported. It is essential to the Ontario integration agenda to support and encourage health care providers to communicate with each other across complex organizational boundaries (Glouberman, 2002). The current investments in e-health and electronic information exchange currently underway in the province will be a great support to the identification and use of key quality processes (Ontario SSHA). However, the Ontario Home & Community Care Council<sup>1</sup> believes that the process of improving communication related to transition planning can begin at the local level prior to full implementation of electronic systems.

Most health care providers understand that in the present delivery of health care services, consumers are vulnerable to the lack of coordination and communication between different sectors in the health care system. In this paper, the key quality processes of routine discharge planning from acute care to primary and community care are expanded to examine the need for a new function within the health care

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<sup>1</sup> Established in 2002, OHCCC's members include the Ontario Community Support Association, the Ontario Federation of Community Mental Health & Addiction Programs, the Ontario College of Family Physicians, the Ontario Association of Community Care Access Centres, the Ontario Home Health Care Providers Association, and the Ontario Pharmacists Association.

system called, by the Ontario Home & Community Care Council (OHCCC), "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 on-going system support due to long term mental or physical illness (Gilmartin, 1994). Strong working relationships between providers and willingness to share timely and relevant information in all parts of the health care system are required to support good transition planning for people. Particular emphasis in transition planning is placed on the need for continuity and quality of information exchange as people receive care and move back and forth through the permeable boundaries of all parts of the health care system (Senge, 1999).

In this discussion paper, key quality processes for transition planning between health care providers are suggested. Key quality processes can be defined as those activities which assist organizations in effectively meeting customer demands and are the basic building blocks of communication between health care providers within the system (King: 1994).<sup>2</sup> The clear articulation of key quality processes in transition planning for people sheds new light on health care 'system' performance outcome indicators, such as overall decreased unplanned readmissions to acute care for both mental and physical health reasons.

Further research work needs to be done to identify outcome measurements which appropriately capture the increased efficiency and effectiveness of the Local Health Integrated Network (LHIN). This paper suggests that tracking the movement of specific, identifiable sub-populations 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). Tracking movements of persons as they seek health care is greatly supported by the current investments in e-health and privacy legislation which are now well underway in Ontario.

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<sup>2</sup> Quality efforts involve monitoring a process (communication) and systematically eliminating causes of unsatisfactory performance

This paper asserts that when specific system performance outcome indicators related to improved communication have been identified, data about current system practice can be measured and base-line levels of system function can be set. Once current base-line data is in place, measurable time targets for system performance improvement can be identified. Each health care 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 they move toward the achievement of a truly integrated ‘system of care’ for people at the local level.

## KEY QUALITY PROCESSES OF CARE TRANSITIONS

### *From primary care and community services to emergency and within the acute care sector*

- A) Is there a process in Emergency to identify persons at high risk for transition planning needs?
- B) Is there a process in Emergency to include patient, family and caregivers in the gathering of relevant medical and social history which will affect transition?
- C) Is there a process to notify the family physician regarding the Emergency presentation of a person requiring transition planning and request appropriate information?
- D) Is there a process in Emergency to involve appropriate multidisciplinary staff necessary for the identification of complex transition issues?
- E) Is there a process to transfer relevant information about the medical care and the supports being provided in community to emergency staff?
- F) Is there a process to ensure that relevant information is obtained from the community health care providers in a timely fashion?

G) Is there a process to ensure that hospitals are asked for input regarding their satisfaction with the transfer process by key stakeholders such as community health care providers and family physicians?

H) Do key stakeholders have a process to incorporate information from customer satisfaction surveys into an improved practice model?

I) Is there a process to evaluate the internal key quality processes with respect to improving the practice model?

## KEY QUALITY PROCESSES OF CARE TRANSITIONS

### *From within acute care to community*

A) Is there a process in the acute care setting to involve appropriate multidisciplinary staff necessary for the identification of complex transition planning needs?

B) Is there a process to notify and include family physicians and relevant community health care provider input into the admission process of the acute care setting?

C) Is there a process within the institution to ensure the timely transfer of relevant information concerning the transfer of the patient to the community?

D) Is there a process 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)?

E) Is there a process to communicate the anticipated date of acute care discharge to the patient, family, family physician, community health care providers and other relevant acute care staff?

F) Is there a process to involve the family and caregiver in all aspects of preparation for the transition back to the community, including their preferences, perspectives and values?

G) Is there a process to educate the patient and family about the health care system, the responsibilities of the health care providers, the rights and responsibilities of the person and informal caregivers in the management of their health care issues, in the transition planning process, and contact information?

H) Is there a process within the acute care system to communicate in a timely and responsive way with the community health care providers, family physician and pharmacist (if required) to notify and involve them in the preparation of transition plans?

I) Is there a process to ensure the patient has access to the necessary/required supportive equipment (assistive devices, medical equipment & supplies) prior to transition?

J) Is there a process to ensure that an acute care contact is available following transition to ensure continuity of the transfer process?

K) Is there a process to ensure that proper medications are available within the first 24 hours of transfer?

L) Is there a process to ensure that the relevant community health care providers are asked for input regarding their satisfaction with the transition planning processes within the acute care sector?

M) Is there a process to ensure that health care consumers are asked for input regarding their satisfaction with the transition processes in the acute care sector?

N) Is there a process to incorporate information gleaned from all customer satisfaction surveys to improve upon current hospital discharge planning practices?

O) Is there an internal evaluation process to complement the external evaluation process?

## KEY QUALITY PROCESSES OF CARE TRANSITIONS

### *Within the community*

- A) Is there a process to include the client and family in the preparation for the transition, including acknowledgement of their perspectives, values and preferences?
- B) Is there a process to include family physician input into the transfer process?
- C) Is there a process to understand the information needs of the receiving caregivers and customize information exchange regarding the transition to meet the needs of these providers?
- D) Is there a timely process to transfer the relevant and needed information regarding the care of the person?
- E) Is there a process to ensure that the receiving caregivers are asked for input regarding their satisfaction with the transfer process of the sending caregiver?
- F) Is there a process to ensure that clients, their family members, and other informal caregivers are asked about their satisfaction regarding the transfer process?
- G) Does the sending caregiver have a process to receive feedback about customer satisfaction from receiving caregivers such as family physicians, pharmacists, long term care facilities and relevant community health providers?
- H) Do sending caregivers have processes to incorporate information gleaned from customer satisfaction surveys into an improved practice model?

### > > > **POTENTIAL OUTCOME INDICATORS FOR IMPROVED > > > **HEALTH SYSTEM FUNCTION****

- A) Increased customer satisfaction with transition planning processes across the various sectors of health and social care (McWilliams: 1993)
- B) Decreased unplanned readmission rates and/or fewer total days of hospitalization for specified target populations (Shulkin: 1993)

- C) Reduction in re-hospitalization rates and cumulative lengths of stay of certain types of persons with life-long illnesses (Parfrey: 1994)
- D) Improved relationships between family physicians/community health care providers and hospitals leading to increased linkages and better care for persons (McWilliams: 1993)
- E) Greater efficiency and quality in placement planning for persons requiring on-going supportive living arrangements (Murphy, G.: 1977)
- F) A reduction in the use of emergency services and broader social services such as police, the justice system, and shelters for persons with mental health & addiction issues (Social Planning Research Council, 2003)
- G) Total system cost reduction due to better and more efficient use of health care resources (Naylor: 1991)

# INTRODUCTION

Health programs are largely funded and managed independently of one another.<sup>3</sup> Yet, health care consumers are dependent on these organizations to work together seamlessly across all organizations and levels of care in the health care system.

The changing demographics and patterns of health care use by health care consumers are creating a quiet revolution in the way care delivery is designed and in the way transition planning is managed across the continuum. Consumer dependency upon good transition planning is further enhanced due to pharmaceutical and technological advances which not only prolong life, but generally extend the life-span of persons living with chronic illnesses (Zwicker, D, 2003). Persons of all ages, who are challenged with long term medical and mental health needs require a health care system that supports their on-going need for care transitioning across the system. These persons will continue to use many sectors of the health care system on a repetitive and more frequent basis. Transition planning must be broad and inclusive of all health care providers in order to support persons, especially at critical interface points between organizations and institutions. Unfortunately, it is at these critical interface points where information about treatment plans often becomes lost or miscommunicated during the transition of the client from one sector to another (Hollander, 2000).

In the present environment of financial constraints, shortened lengths of stay in acute care, overwhelmed emergency departments, and higher acuity of patients being cared for in the community, it is necessary to review current processes of transition planning. Planning for the transfer of health and social care from one service to another is a process requiring:

- Client-focused, organizational collaboration, cooperation and accountability in order to eliminate service delivery barriers;
- Excellence in information exchange and more work on electronic exchange of information coupled with security about privacy of persons; and

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<sup>3</sup> This includes community support services, public health, community health centres, CCACs, home care providers, mental health, acute/chronic/rehabilitation hospitals, pharmacies, laboratories, long term care facilities, all physician services and nursing and multidisciplinary services.

- An appreciation of the broader determinants of health which affect health and function, such as the need for social supports, adequate income and healthy physical environments (Shepperd, et al, 2004). The provision of good public health information and education is critical to prevent injury, illness and diseases at the outset and help people manage their health issues effectively.

A guiding principle underpinning all transition planning is the fundamental right of each individual to be self-determining, to exercise choice and to be treated with respect, dignity and compassion.

## **LITERATURE REVIEW – ROUTINE DISCHARGE PLANNING**

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While much of the literature and research in this field focuses on the routine discharge of a patient from hospital to home, the same general principles can be applied to the transfer of a person from the community to the hospital, or from one community caregiver to another. In a true ‘systems’ paradigm, transition planning becomes the management of a complex two-way interface between institutions and community-based service providers. The two-way nature of this information exchange implies an on-going and continuous relationship between providers of care, permeable boundaries and the need for enhanced accountability between care providers in different sectors. In fact, integration of clinical information systems across sectors is one of the key features proposed in the design of integrated delivery systems which provide a continuum of care for defined populations (Leatt, et al: 1996).

Research about discharge planning as a routine one-way process from the acute care sector spans a thirty-year period, beginning with Skeet’s early work in 1970 (Skeet:1970). Over time, many studies have shown that discharge planning is a vital component of the smooth transition of an individual from the acute care system to the community (Amos: 1973, Roberts: 1975, Gay and Pitkeathly:1979). Information management, and the timely involvement of community caregivers during discharge planning, particularly for the frail, elderly patient, have often been cited in the literature (Jackson: 1990, Vydelingdum:1989).

A literature review reveals that the benefits of comprehensive discharge planning for the elderly in the acute care sector can result in lower readmission rates, fewer total days of re-hospitalization, and lower charges for health care services after discharge

(Naylor:1991). Findings also suggest that preventive intervention has its greatest impact in delaying or preventing re-hospitalization of patients who require medical, as opposed to surgical, care (US. Department of Health and Human Services: 1994). Comprehensive routine discharge planning in the acute care sector has also been shown to reduce the actual length of total hospital stays, however, this is very dependent on enthusiastic implementation, and on-going attention to the process (Parfrey et al: 1994). A 1996 study at ICES outlined that comprehensive routine discharge planning aids in utilization management in the acute care sector. Critical success factors supporting comprehensiveness in one-way discharge planning from acute care include:

- Setting an anticipated date of discharge for all patients 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)
- Ensuring that patients receive an appropriate level of care when occupying acute care beds and provision of supports to prevent delays in care processes
- Identification of patients at risk for long lengths of stay and appropriate referral to services and departments needed to facilitate the discharge planning processes (Basinski: 1996).

One-way discharge planning in the acute sector has been described as a "period of preparation", necessary for arrangements to be made and embraces adequate notice of discharge, discussion of aftercare arrangements, arrangement of aftercare and liaison with community services (Armitage:1981), including preparation and education of the family and other caregivers (Booth and Davies: 1991).

- A qualitative analysis of the process of discharge planning, as seen from the viewpoint of the patient and family reveals that discharge planning is a flexible and dynamic process which is also quite susceptible to breakdown due to a number of factors, these factors could include failure to include the family and patient in the plans for discharge, failure to make the process truly "client-focused", and failure to involve community caregivers early, and throughout the process (Jewell: 1993:1288).

Qualitative research, drawn from a cross-section of health care professionals, administrators and community service agencies in Toronto, Ontario, suggests that an

integrated model contain essential elements constituting an ideal approach to discharge planning. These include:

- The patient as the centre of the process;
- A discharge planning/social work manager;
- A family member, the hospital-based doctor, the family doctor and a community-based person are also central to the discharge planning process;
- Other professionals involved in discharge planning as the need arises;
- Open and continuous communication;
- Timing of discharge planning which is closely linked to the patient's clinical situation; and
- The creation of written, time-ordered actions that guide and direct discharge planning (Wells et al: 1997).

## **DISCUSSION**

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### **Key Quality Processes**

How is quality ensured in a transition process? This question is particularly appropriate to ask as the entire health care system shifts its primary focus from the treatment of the younger, episodically ill patients to the on-going support of frail elderly persons and persons of all ages with a life-long medical or mental illness. A critical success factor in assuring quality lies in the identification and application of intersectoral key quality processes for transition planning. Once identified, these processes can be standardized across sectors in order to improve current practices.

Key quality processes can be defined as those activities which assist organizations in effectively meeting customer demands (King: 1994). Using the combined research of the past thirty years in the area of routine one-way discharge planning, and the practice wisdom of health care providers and consumers, the following key quality processes can be applied to the transitional movement of clients through the health care system.

### *From Community to Acute Care*

**a) Is there a process in Emergency to identify persons at high risk for transition planning needs?**

Early identification of issues in the Emergency Department requires attention being paid to medical and social issues which impact on the transition process. Current examples include the use of screening tools which could identify those persons at risk for difficulties in the transition planning process. (Parfrey et al: 1994)

**b) Is there a process in Emergency to include patient, family and caregivers in the gathering of relevant medical and social history which will affect transition?**

Screening tools which flag relevant transition planning issues can be designed which are completed by patient, families or caregivers. High risk patient populations can be identified for future support of the person, (e.g. research demonstrates that persons at high risk for long stay in acute care include the frail elderly female person, living alone, with two or more co-morbidities, and multiple visits to family doctor within a set period of time prior to ER presentation). If patients are unable to complete tools, assistance should be given in order to fully understand the information the patient can bring to the process.

**c) Is there a process to notify the family physician regarding the Emergency presentation of a person requiring transition planning?**

Family physicians need to know if their patients has presented in Emergency, even if the presentation does not result in an admission. Information about the Emergency Department presentation assists the family doctor in understanding the patient's care needs, and over time, can provide useful chronological data about the persons' requests for care.

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<sup>4</sup> For the purposes of clarity and to introduce a new concept, this paper will substitute the words 'transition planning' for 'discharge planning'

**d) Is there a process in Emergency to involve appropriate multidisciplinary staff necessary for the identification of complex transition issues?**

Patients who present in Emergency often have critical medical, surgical, and/or health needs which must be attended to quickly. At the same time, the team including social workers can identify and attend to the complex social issues which may result in challenging transition issues.

**e) Is there a process to transfer relevant community health care providers' information regarding previous care and support of the person in the community?**

The transfer of information from the community sector to the acute care system is relevant in assisting the process of acute care treatment as well as facilitating the beginning of the transition planning process. Very frail, elderly persons, or persons of all ages with life-long physical or mental illnesses have been cared for very successfully in the community sector for months, or even years.

Important information includes current medications, prescriptions, over-the-counter, and herbal treatments, caregiver involvement, personal care needs and supports, recent medical, surgical or mental health events which might impact on the treatment provided in the acute care admission, family involvement or assistance from significant others, names of power of attorney and any information concerning advanced directives which are known by the community caregivers or family. The transfer and incorporation of this information into the hospital care plan is essential to ensure on-going continuity of care and quality transition planning for the person at the end of the acute care admission.

**f) Is there a process to ensure that relevant information was received from the community in a timely fashion?**

Data systems to measure and track the transfer and the timeliness of information exchange is critical to ensure that community care plans can be maintained throughout the acute care stay. An example might include information about a client's existing relationships with certain vendors for equipment. If this information is available, then transition planning from the acute care sector can be expedited.

**g) Is there a process to ensure that hospitals are asked for input regarding their satisfaction with the transfer processes of key stakeholders such as community health care providers and family physicians?**

Receiving relevant, timely and valid information from community health care providers and family physicians is key to managing the complexity of care transitioning from the community sector into the hospital. It is essential that opportunities to receive feedback about the relevance, timeliness and usefulness of data are provided to community health care providers and family physicians. Information exchange could take place in the form of face to face meetings with representatives of each sector, case reviews of situations which illustrate positive and negative experiences, monthly reports of customer satisfaction or system research.

**h) Do key stakeholders have a process to incorporate information from customer satisfaction surveys into an improved practice model?**

To be effective, community health care providers and family physicians should modify practices that further assist the acute care sector in the transition of patients from the community.

## KEY QUALITY PROCESSES OF CARE TRANSITIONS

### *From within acute care to community*

**a) Is there a process in the acute care setting to involve appropriate multidisciplinary staff necessary, including social work, for identification of complex transition planning issues?**

Too often, appropriate multidisciplinary staff are not involved early in completing the assessments necessary to plan for a quality transition from the acute care sector. This information is critical to ensure that community caregivers can incorporate this information in the post acute period of care.

**b) Is there a process to notify and include family physician input in the admission process to the acute care sector?**

Family physicians have relevant information regarding the on-going treatment and care of individuals in the community. It is important that they are notified promptly of the admission in order to maintain continuity of care and to participate in plans for transition back to the community. Notification should include information regarding the location of the patient within the hospital system. Notification could be done electronically, by fax or phone and should take place whenever the patient is moved in order to promote efficient and effective care.

**c) Is there a process within the institution to ensure the timely transfer of relevant information concerning the transfer of the patient?**

Continuity in information exchange within the organization is critical to ensure good quality in the transition planning process. Every time a patient is moved within the acute care sector, information must be exchanged seamlessly to ensure that plans for transition are maintained while acute care treatment is being given. The emerging use of electronic patient records can assist in reducing the loss of information which is critical to the transition planning process.

**d) Is there a process to set an anticipated date of transition 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)?**

Supported by best practice research, the anticipated date of transition is generally a database norm, a hospital's own norm, or another external reference. It is a critical date to set in the process of care because it mobilizes and focuses the acute care team on preparations for transition (Besinski: 1996).

**e) Is there a process to communicate the anticipated date of transition to the patient, family, family physician, community health care providers, caregivers and other relevant hospital staff?**

This anticipated date of transition should be flexible and dependent on the patient's clinical condition. However, it is important for the patient, the family and the health care team to have a goal towards which they must strive in planning the process of transition. Community health care providers and family physicians should also be

notified of the anticipated date so that pre-planning for transition can begin in the community sector.

**f) Is there a process to involve the family and caregiver in all aspects of preparation for the transition including their preferences, perspectives and values?**

This involvement can take many forms such as face to face meetings, telephone conferences, the development of patient education and patient transition planning booklets. To ensure quality of the transition process, the preferences, perspectives, and concerns of patients and family must be attended to by acute care staff.

**g) Is there a process to educate the patient and family about the health care system, the responsibilities of health care providers, the rights and responsibilities of the person and informal caregivers in the management of their health care issues, in the transition planning process, and contact information?**

The development of patient and family education information specific to their particular health care concern would assist the patient and family to become more knowledgeable about the care needs they have, how to manage their health issue effectively, and who to call for assistance once transition back to the community has taken place. This is particularly important for persons with life-long illnesses.

**h) Is there a process within acute care to communicate in a timely and responsive way with community health care providers and family physicians to involve them early in the preparation of transition plans?**

Communication with family physicians and community health providers is key to the successful transition of the person. The development of simple communication tools should list such information as the current medications of the patient, the new care giving needs or assistive devices required, the medical or social issues which need to be addressed by the family doctor and relevant community health care providers. This information could be sent electronically, faxed or sent with the person.

**i) Is there a process to arrange for relevant products (assistive devices, medical equipment and supplies) prior to the transition?**

Communication difficulties which result in delayed discharges, or worse, unplanned readmissions, often relate to the need for the proper equipment to be ready at the time of transition. Seamless communication within the acute care sector is necessary to prepare the home to receive the individual.

**j) Is there a process to ensure that a hospital contact person is available following transition to ensure continuity of the transition process?**

While this may seem to be an unnecessary part of a comprehensive transition planning process, the availability of a contact person ensures accountability and provides an important bridge across the interface separating hospital from the community.

**k) Is there a process to ensure that proper medications are available within the first 24 hours following transition?**

As acute care settings have their own internal formulary and some patients can be switched from their medications to an "equivalent" one in the hospital setting, it is imperative to communicate this type of change back to the community level to avoid any potential medication errors.

Medications which are always available in the acute care setting may not be available in the community or may not be on the ODB list. Patients may not be able to afford the medication and substitutes will need to be identified. Drugs such as morphine may have to be specially ordered by pharmacies which do not ordinarily carry this product or they may have to be provided by the hospital for the first 24 hours.

**l) Is there a process to ensure the relevant community health care providers (including family physician) are asked for input regarding their satisfaction with the transition processes in the hospital?**

Requests for community health care provider feedback could be derived from questionnaires, structured interviews or focus groups led by skilled facilitators. These feedback sessions should include opportunities for respondents to expand on their ideas for improved service.

**m) Is there a process to ensure that health care consumers are asked for input regarding their satisfaction with the transition processes in the hospital?**

As with the preceding standard, health care consumer feedback could be derived from questionnaires, structured interviews or focus groups (Larson, BW, 2004). Family members and other caregivers should be involved in the process of transition. Information could also be solicited during hospital stays, especially if the transition process has been lengthy or complicated.

**n) Is there a process to incorporate information gleaned from all customer satisfaction surveys to improve upon current hospital transition planning practices?**

The processes of requesting customer feedback is one of the most important aspects of the continuous quality improvement model. As important as requesting the information is the ability of the organization to incorporate new learning into the improvement of current practices. This model is heavily dependent on data systems which are able to assist managers in measuring and tracking important trends.

## KEY QUALITY PROCESSES OF CARE TRANSITIONS

### *Within the community*

Other forms of care transitioning occur within the community when a person moves

- from the community to a long term care facility;
- from a retirement home to independent living with varied home and community care supports
- from one type of home and community care or mental health service or support to another.

There is a need to articulate the key quality transition processes which would facilitate this movement.

**a) Is there a process to include family physician input in notification of the transition of care?**

The family physician is a key stakeholder in all community movements and should be informed and involved in the plans for changes in care. Family physician input and involvement is a key component to support effective care transitioning of the person.

**b) Is there a process to include the client and family in the preparation for transition, including acknowledgement of their perspectives, values and preferences?**

The person who is transitioning within the community has his/her own perspective, preferences and concerns about the planned change or move. Every effort should be made by those supporting the person in the transition to understand and respond to the wishes of the person in the management of their care.

**c) Is there a process to understand the information needs of the receiving caregivers and customize information exchange to meet the needs of these providers?**

Customer input into the type of information which is to be sent will improve satisfaction with information exchange between, and among, community providers. Customized information exchange is critical for smooth care transitioning.

**d) Is there a timely process to transfer the relevant, and needed information regarding the care of the person?**

Information exchanges must be customized to meet the needs of receiving caregivers. All too often, sending organizations transmit the same types of information to all receiving caregivers and this may not be the relevant and needed information necessary to carry on with care needs of the person.

**e) Is there a process to ensure that "receiving" caregivers are asked for input regarding their satisfaction with the transfer processes of the "sending" caregiver?**

In a fully accountable system, transferring caregivers should make efforts to ascertain whether their processes and information were timely, relevant and useful to the receiving caregiver.

**f) Is there a process to ensure that clients, family members, and other informal caregivers are asked for feedback regarding the transfer process?**

Clients, families and other informal caregivers are great sources of information regarding their personal experience of the care transition. This information could be obtained through the use of structured interviews, focus groups, phone interviews or mailed surveys (Larson, 2004).

**g) Does the "sending" caregiver have a process to receive feedback about customer satisfaction from key stakeholders such as family doctors, community health care providers, persons and their families?**

Information exchange could take place in the form of formal inter-agency meetings, structured interviews, case reviews of actual situations which illustrate positive and negative experiences, mailed surveys, monthly reports of customer satisfaction based on mutually agreed upon variables.

**h) Do "sending" caregivers have processes to incorporate information gleaned from customer satisfaction surveys into an improved practice model?**

Each sending caregiver should incorporate information received from their customers into improved practice models.

**> > > KEY QUALITY OUTCOME INDICATORS**

What key quality indicators could help to inform the system that processes are effective in improving transition planning? According to the literature, the possible outcomes of an effective and efficient transition process must be quantifiable and measurable in order to measure whether or not improvement has occurred (Senge, 1999). Measurable key quality outcomes of successful transition planning could include the following:

- Increased customer satisfaction (patient and families) with transition planning processes across the various sectors of health and social care (McWilliams:1993)
- Decreased unplanned readmission rates and/or fewer total days of hospitalization (reduced LOS) (Shulkin:1993)

- Reduction in re-hospitalization rates and cumulative lengths of stay of certain types of persons with life-long illnesses (Parfrey: 1994)
- Improved relationships between family physicians/community health care providers and hospitals leading to increased linkages and better care for persons (McWilliams: 1993)
- Greater efficiency and quality in placement planning for persons requiring on-going supportive living arrangements (Murphy, G.: 1977)
- A reduction in the use of emergency services and broader social services such as police, the justice system, and shelters for persons with mental health & addiction issues (Hamilton Social Planning and Research Council, 2003)
- Total system cost reduction due to better and more efficient use of health care resources (Naylor: 1991)

These indicators must be quantifiable and measurable in order to track incremental changes and improvements in measured outcomes. At the outset, the selection of two or three key quality indicators would assist in the development of a cross-sectoral balanced score card. As the comfort level with such individualized and systemic outcomes measurement grow, LHINs could add other indicators to the list.

While the suggested indicators are applicable to all patients/clients, initial success in the application of outcome measurements may be more easily obtained using data from specific sub-populations. Tracking the movement of a specific sub-population across the continuum, (such as those individuals diagnosed with a chronic respiratory disease) may be a beneficial place to begin (Gilmartin, 1994). As the suggested transition planning processes are applied and customized to a population sub-group, outcome indicators such as the rate of unplanned readmissions become more meaningful and manageable. Outcomes indicators such as total system cost reductions due to greater cost efficiencies are also more easily captured and explained.

It is quite conceivable, given this approach, that a LHIN report card could be generated on the "state of the art" in terms of the management of specific sub-populations which require longer-term care and support throughout their life-span. This approach would encourage the development of benchmarks for best practice in the transitioning processes for all patient populations (Saunders: 1996).<sup>5</sup> ) LHINs

should be encouraged to adopt ‘best-practices’ from other LHINs across the province related to transition planning. This model would also interface effectively with care-paths which are being developed within the acute care system and enlarge upon their scope across the broader continuum of care (Leatt: 1996).

## CONCLUSION

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Transition planning is the management of a complex interface, or care transition point, between and among community caregivers and the institutional sectors. It is ideally envisioned as an intersectoral process, dependent upon excellence in information exchange, permeable boundaries and person-focused organizational collaboration and cooperation. Identification of key quality processes and true ‘system’ performance outcome indicators is critical to the development of a systems approach to care across the continuum. Successful management of this process can lead to greater efficiency, effectiveness and accountability for care as the system integration of health care in Ontario progresses.

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<sup>5</sup> A legitimate concern always exists that those individuals with medical or mental health issues which do not fit into a specific category of illness will be short-changed if a sub-population model is used. This paper asserts that the outcomes of quality care transitioning will be more readily apparent by monitoring their use with a specific sub-population. Once established, however, these quality processes should become a part of the improved total system function that would benefit all persons.

## BIBLIOGRAPHY

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Andren, K.G., Rosenquist, U, *Heavy Users of an Emergency Department — A two Year Follow-up Study*, Soc.Sci.Med. Vol. 25, No. 7 825-831, 1987

Basinski, T., Management of Acute Care Bed Resources in Ontario, ICES 1996

Booth, J., Davies, C., *Happy to be home? A Discharge Planning Package for Elderly People*, Professional Nurse, 6(6), 330-332, 1991

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

Farren, E, A., *Effects of Early Discharge Planning on Length of Hospital Stay*, Nursing Economics, Vol 9, No. 1 January-February, 1991

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

Gilmartin, ME. *Transition from the intensive care unit to home; patient selection and discharge planning*, Respiratory Care 1994:39(5):456-480

Glouberman, S, *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) July 2002

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

Jackson, M., *Use of Community Support Services by Elderly Patients Discharged from General Medical and Geriatric Medical Wards*, Journal of Advanced Nursing, 15, 167-175, 1990

Jewell, S.E., *Discovery of the Discharge Process: A Study of patient Discharge form a Care Unity for Elderly People*, Journal of Advanced Nursing 18, 1288-1296, 1993

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

Larsson BW, Larsson G, Carslong SR. *"Advanced Home Care: Patients' opinions on quality compared with those of family members"*, Journal of Clinical Nursing, 2004, 13:226-233

- Leatt, P., Pink, G.H., Naylor, K., *Integrated Delivery Systems: Has Their Time Come in Canada?*, Can. Med. Assoc. J., 154(6), March 1996
- Murphy, F., *Blocked Bends*, British Medical Journal, 1:1395-1396, 1997
- McWilliams, C.L., *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, December 1993
- Naylor, N., Brooten, D., Jones, R., Lavisso-Mourey, R., Mezey, M., Pauly, M., *Comprehensive Discharge Planning for the Hospitalized Elderly*, Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Public Health Service, 1994
- Ontario, Smart Systems for Health Agency, [www.thinksmart.ca](http://www.thinksmart.ca)
- Parfrey, P.S., Gardner, E., Vavasour, H., Harnett, J., McManamon, C., McDonald, J., Dawe, *The Feasibility and Efficacy of Early Discharge Planning Initiated by the Admitting Department in Two Acute Care Hospitals*, Clin. Invest. Med., Volume, 17:2pp. 88-96
- Roberts, I., *Discharged from Hospital*, Royal College of Nursing, London, 1975
- Senge, P., *The Dance of Change*, (Library of Congress) 1999
- Shepperd, S., Parkes, J., McClaran J, Phillips, C., *Discharge Planning from hospital to home* (Cochrane Review) in (*The Cochrane Library*, Issue 3, Chichester UK: John Wiley and Sons, Ltd) 2004
- Saunders, J., *Regional Programs. The Concept and Planning Process*, Calgary Regional Health Authority, 1996
- Shulkin, D., Kinosian, B., Glick, J., et al. The Economic Impact of Infections. *Archives of Surgery*, 128, 449-452, 1993
- Skeet, M., *Home From the Hospital*, Dan Mason Nursing Research Committee, Florence Nightingale Memorial Committee, Macmillan, London, 1970
- Social Planning and Research Council, *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, August 2004

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

Wells, D.L., *A Model for Discharge Planning*, Unpublished Research Paper, Social Sciences and Humanities Research Council Grant, Reported on <http://www.interlog.com/~gethosp/discharge.htm>, Sept. 1997

Zwicker, D, Picariello G., *Discharge planning for the older adult*, In: Mezey M, Fulmer T, Abraham I, Zwicker DA editors(s) *Geriatric nursing protocols for best practice*. 2nd ed. New York (NY) Springer Publishing company Inc; p. 292-316, 2003

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## **Appendix A:**

### **THE ONTARIO HOME AND COMMUNITY CARE COUNCIL**

#### **Purpose**

- > To represent key providers in the home and community care health sector in Ontario to provide a forum to speak with one voice on policy, planning and programming issues to enhance service deliver to our mutual clients.
- > To provide the home and community health care perspective to the Ministry of Health and Long-Term Care and work with the Ministry to stabilize and enhance this sector in the interests of the health care system as a whole.

#### **Objectives**

- > To promote a common vision for the home and community care sector in Ontario
- > To engage in activities to support program enhancements
- > To coordinate the development of research projects that can move the health care sector towards evidence-based decision-making
- > To consolidate the working relationship of the Associations for the betterment of the home and community care sector in Ontario

#### **Membership**

The Council shall have representation from the following Associations:

Ontario Association of Community Care Access Centres (OACCAC)

Ontario College of Family Physicians (OCFP)

Ontario Community Support Association (OCSA)

Ontario Home Health Care Providers' Association (OHHCPA)

Ontario Pharmacists' Association (OPA)

Ontario Federation of Community Mental Health and Addictions Programs (OFCMHAP)

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