

Template #1: Strengths and Challenges within the Current System in Addressing Population Needs

PAG Name Transitional Care

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Strengths and Challenges

Introduction PAG – Geriatrics (frailty and chronic disease)

Almost 15% of Canadians are aged 65 years or over, and the greatest proportional population increase is occurring among octogenarians (StatsCan 01). The rising numbers of older persons is expected to cause a significant strain on health care budgets, as the burden of chronic disease increases with age (Rapoport et al, 2004). Chronic disease management (CDM) approaches have focused on improving outcomes for persons with major chronic illnesses such as diabetes mellitus, heart failure or chronic obstructive pulmonary disease. However, such approaches perpetuate a system of care silos that focus on individual conditions as if they occur in isolation, a model that is unsuitable to the growing number of seniors who suffer from multiple concurrent comorbidities. In Canada, over 40% of persons aged 80 years and over report three or more chronic illnesses (Rapoport et al, 2004). In addition to these chronic illnesses, increasing numbers of seniors are also afflicted by age-associated disabilities and geriatric syndromes such as frailty, functional decline, disability, falls, incontinence, and psychogeriatric disorders such as cognitive impairment, depression and anxiety. In the 2003 Canadian Community Health Survey of 28617 adults aged 65 years and over, 4% of men and 4% of women aged 65 to 74 years required assistance in at least one basic activity of daily living (BADL), and 9% of men and 18% of women required assistance in at least one instrumental activity of daily living (IADL) (Gilmour 05). Among men and women aged 85 years and over, these figures rose to 20% and 23% for BADLs and 46% and 65% for IADLs, respectively. The economic impact of these geriatric syndromes is equivalent to that of major chronic illnesses (Gilmour & Park, 2005; Cigolle et al, 2007; Levy & Muller, 2006; Rubenstein, 2006; Fillit & Hill, 2005; AHA 2002; Szczech & Lazar, 2004).

Introduction to Geriatrics – Frailty and chronic disease management model

Frailty can be understood as a state of increased vulnerability to adverse health outcomes due to age-related decreases in physiologic reserve, and is most often, but not exclusively, found in older persons (Bergman 2007). Frailty bears many similarities to major chronic diseases, as it is more common with age, and leads to disability, increased health resource utilization, and mortality. Perhaps less widely appreciated is that frailty can be a direct consequence of poorly managed chronic diseases such as heart failure, COPD, or diabetes. Moreover, just like these chronic diseases, frailty can be successfully managed. Numerous randomized clinical trials demonstrate that comprehensive geriatric care can reduce mortality, improve function, cognition and quality of life, and prevent hospitalization and institutionalization into long-term care facilities, in a manner that can be cost-effective. Yet, despite this evidence, the management of frailty in our current health care system remains disjointed and inadequate.

In this submission, we propose an integrated system of clinical services to manage frailty at all levels of our health care system. These services will complement existing inpatient consultation services and the regional Geriatric Assessment and Rehabilitation Unit at the Henderson General Hospital, by enhancing the care of frail seniors in the community. The proposed clinical services are based upon the Chronic Disease Model, in which the majority of care provided to seniors is at a primary care level, appropriately supported by multiple disciplines, including advanced practice nursing and other allied health professions. In this model, specialty services, such as geriatric medicine or geriatric psychiatry, play two important roles:

1. Direct patient consultation: patients identified at the primary care level being at greatest risk of adverse events, such as institutionalization, due to complex medical problems and / or geriatric or psychogeriatric syndromes, will undergo comprehensive geriatric assessments delivered by specialized multidisciplinary teams that include a specialist in geriatric medicine or geriatric psychiatry.
2. Capacity building: For most patients to be cared for at the primary care level, specialists in geriatric medicine or psychiatry, as well as specialized allied health professionals will be available to provide primary care providers educational opportunities designed to enhance their capacity to provide care to seniors with mild to moderate frailty.

Introduction to Transitional Care

Over the last several decades, the average length of stay of older patients admitted to acute care hospitals with exacerbations of chronic diseases such as heart failure or COPD has declined significantly. This trend has been associated with a parallel rise in the number of patients discharged with a particular diagnosis and who are shortly thereafter rehospitalized with the same diagnosis. Risk factors for readmission include:

- multiple functional deficits
- polypharmacy, 2+ chronic health conditions
- limited social support system
- 2+ hospitalizations in last 6 months
- poor chronic disease knowledge (Naylor J Cardiovasc Nurs 00, Bowles JAGS 02, Wright Eur J Heart Fail 03; Riegel Nurs Res 07)

These patients are essentially frail seniors.

In order to reduce the risk of readmissions, transitional care initiatives, based on the chronic disease management model, have been developed and evaluated. Transitional care denotes a series of processes or actions to ensure / enhance continuity of care and collaboration between health care professionals, and thus facilitate the safe and timely transfer of patients from one level of care (e.g., hospital) to another (e.g., primary care physician).

The core of transitional care is focused on enhancing the capacity of patients, often with the assistance of their primary informal caregivers (e.g. spouse, child), for self-care. The two primary components of self-care include:

1. **Self-Maintenance:** adherence to treatment and positive health practices
2. **Self-Management:** active process that involves recognizing and responding to symptoms:
 - recognize subtle changes in status;
 - evaluate their significance;
 - take appropriate action to avert further clinical deterioration;
 - evaluate effects of the action taken, and take further action is required.

Educating patients and caregivers on how to assertive and effectively navigate the health care system is a key desired outcome.

A number of randomized controlled trials have demonstrated the clinical benefits and cost effectiveness of this approach. A randomized controlled trial of 239 patients hospitalized with heart failure, aged on average 76 years and with 6 active comorbidities, evaluated an Advanced Practice Nurse (APN)-led Self-Care intervention in which individualized plans of care addressing comorbidities and social issues were developed for each patient (Naylor MD J Am Geriatr Soc 04). In addition to hospital visits, the APN visited the patient the day after discharge, and up to 7 more times during the 3 subsequent months. After a follow-up of 1 year, the intervention results in substantially fewer heart failure deaths and rehospitalizations, as well as in fewer rehospitalizations for comorbid illnesses, at a cost-saving of \$4845 per patient.

A second trial enrolled 750 pts aged on average 76 years, with various diagnoses including heart failure, stroke, coronary artery disease, arrhythmia, COPD, diabetes mellitus, spinal stenosis, hip fracture, peripheral vascular disease, and venous thromboembolic disease (Coleman Arch Intern Med 06). The intervention also focused on self-care, including assistance with medications, development and maintenance of a patient-centred and owned medical record (passport), timely follow up with primary or specialty care, and development of a list of red flags to detect early illness decompensation and plans for response to avert a readmission. An APN performed one home visit as well as 3 follow-up phone calls during the subsequent 28 days. The intervention resulted in a reduction in readmission for the index diagnosis at 6 months, and saved \$500 per patient.

Finally, a randomized controlled trial enrolled 2370 pts, median age 80 and with various diagnoses including fractures, neurological disorder, cardiorespiratory disease, and cognitive impairment (Cunliffe Age Ageing 2004; Miller Age Ageing 2005). The intervention was provided by a multidisciplinary team of allied health professionals who provided patients and their caregivers with self-care education, therapy and personal support following hospital discharge. The intervention resulted in fewer total hospital days for up to one year, as well as improved performance of instrumental activities of daily living at one year, and reduced caregiver burden during the first 3 months after hospital discharge. The intervention was associated with a savings of £1727 per patient.

Reflecting the strength of the evidence from these clinical trials, the Canadian Cardiovascular Society Heart Failure guidelines endorse the role of transitional care programs in preventing hospital readmissions among frail older persons with heart failure (Arnold et al, Can J Cardiol 2008).

In response to this recommendation, a Transitional Care Team funded through the Aging at Home strategy, was established in Hamilton in the fall of 2008. This team consists of Acute Care Nurse Practitioners, working in conjunction with the Hamilton Niagara Haldimand Brant Community Care Access Centre (Hamilton branch), and targets frail older patients with heart failure or COPD and who are hospitalized at the General and McMaster sites of Hamilton Health Sciences. Thus far, over 110 patients have been enrolled. The effect of the program on patient self-care knowledge, functional ability, quality of life, and readmissions, as well as on caregiver burden and quality of life, is being evaluated in a study approved by the McMaster University Research Ethics Board. Preliminary data presented at the Annual Meeting of the Canadian Geriatrics Society in April 2009 demonstrate significant increases in patient self-care knowledge, with no significant decline in patient function, as well as no increase in caregiver burden. The readmission rate for both COPD and heart failure at 3 months was 18%, which compares favourably to rates of readmission for heart failure alone reported in the literature (Phillips et al JAMA 2004).

Proposed Enhanced Program Model

This proposal builds upon the Transitional Care Model described above that has been funded through AAH. Once fully implemented, all older hospitalized patients with mild to moderate frailty will be eligible for Transitional Care support upon discharge from hospital. Currently, patients with heart failure and COPD are eligible. **Eligible diagnoses will be expanded** to include, among others, diabetes mellitus, pain, neurological disorders (e.g. Parkinson's disease, stroke), coronary artery disease, as well as the other diagnoses noted in the introduction above. Patients will be identified early during the course of hospitalization and assessed and followed by a specially trained nurse. Upon discharge, patients will be seen within 48 hours, whereupon the self-care education will begin. Patients will be enrolled for at least 4 weeks, and for up to 3 months as required.

It is important to recognize that no more than half of clients served by the CCAC are referred from hospital, with the other half referred directly from primary care or from other outpatient sources (personal communication from Dr. Jeff Poss, University of Waterloo). It is expected that a substantial proportion of these patients will also suffer from multiple chronic diseases, and will thus also be able to benefit from the self-care education delivered by the Transitional Care Approach. As long-stay CCAC clients are regularly assessed by CCAC case managers using the RAI-HC suite of instruments, we will be able to utilize these instruments to identify clients eligible for Transitional Care, this time with the additional aim of preventing an admission to hospital.

The RN Role

Currently in Hamilton, consistent with the literature, the RN role is provided by an Acute Care Nurse Practitioner trained in adult education as well as adult medicine. Ultimately, the role of the ACNP will be to become a resource for the program and **to train registered nurses to perform the self-care role.**

Input from Geriatric Specialists

The Transitional Care Model is essentially a primary care model for complex patients, consistent with the Chronic Disease Management approach. A certain proportion of patients (approximately 20%) will be particularly complex and will benefit from the input of specialists in Geriatric Medicine or Geriatric Psychiatry. Therefore, part of the initial and ongoing assessment of patients by the RN will include the use of standardized instruments to assess individual patients' degree of frailty and risk for subsequent adverse health outcomes. Patients at high risk will be seen in consultation by a Geriatric Medicine or Psychiatry specialist. Please refer to the "athome outreach" and "primary care shared model" descriptions for a better understanding of how these programs relate to each other.

In addition to a direct consultative role, specialists in Geriatric Medicine and Psychiatry will assist primary care in developing the capacity to manage frail older patients through ongoing clinical education activities, journal clubs, and workshops.

Data collection and evaluation

Data shall be collected in order to evaluate the effectiveness of the program. In addition to RAI-HC data (as the program will run as an enhanced CCAC service), we will utilize standardized instruments to collect data on patient self-care knowledge, quality of life and caregiver burden. The RAI-HC data may assist us in the comparing the effectiveness of the program with historical control groups, as well as with other Ontario LHINs.

Template #2: Factors Most Likely to Increase or Decrease the Future Demand for Health Care:

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<p>As of 2006, the HNHB LHIN was home to over 200,000 seniors aged 65 years and older; the largest number of seniors of all LHINs. In 2006, seniors 65 years of age and older represented 15.8% of the total HNHB LHIN population, compared to 13.6% for all of Ontario.</p> <ul style="list-style-type: none"> • Twenty-nine percent (29%) of seniors aged 65+ live alone in HNHB communities, higher than the provincial average of 27%. Within HNHB the highest proportions of seniors living alone are found in St. Catharines (33%) and Brantford (33%) and the lowest proportion in Wainfleet (19%). • Seniors living alone may be at greater risk of social isolation. The lack of social support among the elderly contributes to poor health status and the need for formal and institutional care. <p>Approximately 27.7% of seniors in the HNHB LHIN live alone (See Table 2). Seniors living alone may be at greater risk of social isolation. The lack of social support among the elderly contributes to poor health status and the need for formal and institutional care. A recent Statistics Canada study demonstrated that the vast majority of seniors remain in the community as their health care needs increase. Between 1981-2001 the proportion of Canadians aged 65+ living in health care institutions remained at about 7%; in 2001, approximately one-third of Canadians age 85+ lived in an institutional care setting. Among seniors living in the broader community, the Ministry of Health and Long-Term Care estimates that relatives, friends and volunteers provide about 80% of support to seniors with needs.</p> <p>The majority of seniors that live in the HNHB LHIN live within Hamilton and Niagara (See Figure 1). In terms of absolute numbers, Hamilton and Niagara are each home to over 74,000 seniors 65 years of age and older, and together represent 72% of the total HNHB LHIN population over 65 years of age.</p> <p>Population aging presents significant challenges to the health care system in Ontario. Not the least of these is the fact that 82% of seniors have one or more chronic health condition and 43% have three or more chronic conditions. This latter group is at risk of becoming frail. Frailty, characterized by complex bio-psycho-social and functional problems, is associated with increased health system usage and puts seniors at risk of loss of the capacity for independent living and lowered quality of life (Wolff et al, 2002). Within the aging demographic, frailty may be the fastest growing issue across the province and particularly in northern regions and outside high-density urban areas (Manuel & Schultz, 2001).</p>	<p>Significant impact on future demand for health care</p>

<p>Transitional Care</p>		
<p>The ageing of the Baby Boomers will be the main driver of the increased number of people who are 65 years and over. These numbers will increase by 50% over the next 10-15 years. Improved life expectancy will also see the numbers of people aged 80 years and over double during the next two decades. As we live longer we are likely to see an increasing proportion of people with age related medical disorders such as neurodegenerative disorders, depression and mental health problems (Hopkins & Hopkins, 2005).</p> <p>A key contributor to the increase in severe disability experienced by those over 80 is growth of neurological conditions, which result in disorders of memory, cognition, behaviour, motor and sensory functioning, mobility and balance. These neurodegenerative diseases are often slowly progressive and they have not, so far, been amenable to prevention or delayed onset, as have other disorders such as heart attacks and stroke. While there is no strong evidence that the incidence of these diseases is changing, their prevalence is rising rapidly as more people are living longer. We can expect the systemic disorders to be overtaken by neurodegenerative diseases as the major cause of death in older people during the coming decades and also the major cause of severe disability.</p> <p>People will come out of hospital with the capacity to get better and it will be important that the health system has a strong focus on <i>restorative and preventative measures</i>. The demand for rehabilitation and other services following these acute events will certainly increase. In response to these trends we may benefit from a hospital sector that plays a greater role in preventing acute admissions to hospitals and delivers more services in the community.</p>	<p>Significant impact on future demand for health care</p>	
<p><i>The Dementia Epidemic:</i></p> <p>In Ontario, dementia is the leading cause of disability for those over 60 years of age causing more years lived with disability than stroke, cardiovascular disease and all forms of cancer (Alzheimer Society of Ontario, 2007). It is expected that by 2010, 175,000 Ontarians will be living with dementia; this will increase by almost 127% by 2020 (Hopkins & Hopkins, 2005). Table 1 presents the estimated incidence of dementia in the HNHB LHIN for 2006.</p> <p>Ageing demographics will have a significant <i>impact on human resource planning</i> and development in all professions working in many health care contexts across the circle of care (McKnight et al. 2003). Providing care to this expanding population of frail seniors requires both an increase in the numbers of care providers, capacity building across various health care sectors, and restructuring of how and where we deliver care. Our skill sets require expertise in three broad competencies - geriatrics, inter-professional practice and inter-organizational collaboration.</p>	<p>Significant impact on future demand for health care</p>	

Transitional Care

Table 1: Estimated Incidence of Dementia in the HNHB LHIN, by County and Age Group, 2006.

Geography	Age Group						Total (60+)
	60-64	65-69	70-74	75-79	80-84	85+	
Brant	31	50	93	173	291	533	1,171
Burlington	45	73	134	238	391	667	1,548
Haldimand-Norfolk	31	48	86	148	242	438	994
Hamilton	125	207	386	742	1,242	1,968	4,670
Niagara	121	204	378	704	1,201	1,997	4,605
HNHB LHIN	353	583	1,077	2,005	3,367	5,603	12,988
Ontario	2,984	4,872	8,578	15,146	24,486	42,003	98,069

Source: Statistics Canada, 2006 Census; Dementia Age Relative risk: 60 1%; 65 2%; 70 4%; 75 8%; 80 16%; 85+ 32%. Source:

Competence in geriatrics is required because the clinical presentations of frail seniors are unique and include the ‘geriatric giants’ of dementia, delirium, falls, continence and poly-pharmacy. These often co-exist in complex ways. Competence in inter-professional practice is required because the complexities of these clinical presentations are such that optimal care requires an interdisciplinary team. Inter-professional teamwork, as outlined in the recently published Health Force Ontario, Inter-professional Care: Blueprint for Action (Oandasan & Closson, 2007), is the care delivery method of choice in caring for frail seniors (Geriatrics Interdisciplinary Advisory Group, 2006). Finally, competence in inter-organizational collaboration is required because the management of frail seniors requires the sharing of care across many organizational boundaries from primary and community based care to emergency and hospital-based services.

Significant impact on future demand for health care

Advancement in technology and how we communicate with each other

Based on this aging population and HR challenges we need to develop e – health strategies such as video conferencing, maximize electronic record sharing such as clinical connect, standardize all documentation processes to facilitate data collection, evaluation and reduce redundant assessment practices that are a further burden on staff and patients and families. Common forms and tools will create more effective practice and help different teams start communicating AS ONE. Common documentation will facilitate rapid and improved transfer of information. Capacity building will be much easier and bench marking will be attainable.

Significant impact on future demand for health care

Transitional Care	
<p>Patients/clients need to assume more responsibility for their care. Work has been done using patient passports and best practice needs to be implemented using principles from the chronic disease model, e.g., flag prevention measures, telephone follow up to reinforce messages etc.</p> <p>Video conferencing is now being tested by geriatricians and office space has been secured. Geriatricians will be among a very small group in the province of Ontario to actually use video conferencing for clinical purposes. We are just beginning to understand the full ramifications of this technology.</p>	<p>Significant impact on future demand for health care</p>
<p>How services are offered</p> <p>As frail seniors decondition rapidly in hospitals e.g., losing muscle mass, delirium, infections etc., it is imperative that services are designed that prevent admission and re-admission and help people live longer in their homes with a good quality of life. The specialty of geriatrics can not tackle this problem single handedly. Using a collaborative model, we propose developing a shared care model with family health teams and community health centres. Building expertise in geriatrics across the continuum with targeted specialist support will help multi-disciplinary groups identify seniors at risk. We need to equip primary care settings to be responsive to seniors at risk so they can provide time sensitive support to hospital discharges or seniors presenting in emergency who can return home with expedited clinical support. Having a flexible team that can provide outpatient and at home outreach services is critical. Many seniors in our LHIN live in isolated situations and are at risk.</p>	<p>Significant impact on future demand for health care</p>
<p>Best practice</p> <p>We know that targeted care to frail seniors makes a difference in health outcomes. Evidence indicates that interdisciplinary teams on an inpatient and outpatient basis is important. Comprehensive Geriatric Assessment targeted at frail seniors responds to immediate issues and prevents other medical conditions from worsening. Home visits will improve overall functioning and help seniors live more independently. Teaching seniors more about their health and how to manage their care more proactively is an integral part of the care process. Already, we have positive results in the Transitional Care program through Dr. G. Heckman that shows teaching frail seniors is effective and helps them stay out of hospital. Using communication strategies like providing patients a copy of their treatment plan, having them bring their patient passport to all health care appointments is an important health information tool. This will introduce evidence based practice for meeting the needs of aging population</p>	<p>Significant impact on future demand for health care</p>

Transitional Care	
<p>What factors are expected to influence the demand for health care beyond 2013?</p> <p>Practice of geriatric care is clustered in urban centres, primarily Hamilton</p> <p>Rapidly growing older adult population with shortage of geriatric specialty trained health care professionals across all sectors of health care including primary care and community.</p> <p>Movement of older adults to retirement communities, often smaller towns with poorly established geriatric health services and limited family and transportation</p> <p>Finite number of Long Term Care beds</p>	

Template #3: Components of an Ideal Service Delivery Model

PAG Name Transitional Care		PAG Facilitator Dr. George Heckman	
Component of service delivery model	Services associated with this component of the model	Clinical and non-clinical interdependencies (e.g., DI, lab, other programs/services, other PAGs)	Linkages to community services
Health Promotion/Disease Prevention	Enhancing self management Targeted towards secondary prevention e.g hospital admissions for indexed and other diagnosis, adverse reactions		Pharmacy support re: medication management, linkages to programs to help maintain function – falls, memory, diabetic, continence advisors. Take actions early on to prevent further deterioration in health. Increase confidence and knowledge
Primary Care	Identify population CHF COPD and refer Screening to prevent from getting to the point to be admitted to hospital Some can be managed by primary health Geriatrician build capacity in FHT/family physicians –through consult and provide advice Chronic disease management model	CCAC FHT attachments Geriatrician	Linkages with Alzheimer’s Society – First Link, Diabetic Management Programs Pharmacy home visit or med review program
Pre-hospital Care			
Acute Hospital Care	Identify population requiring program – CHF, COPD upon ED admission or inpatient and refer Those with dementia and Diabetic Management programs Case finding – daily team rounds Need electronic system to flag potential referrals Frailty scales can assist in case finding	Need champions and key individuals to identify – OT SW PT	Linkages with Alzheimer’s Society – First Link Diabetic Management Programs

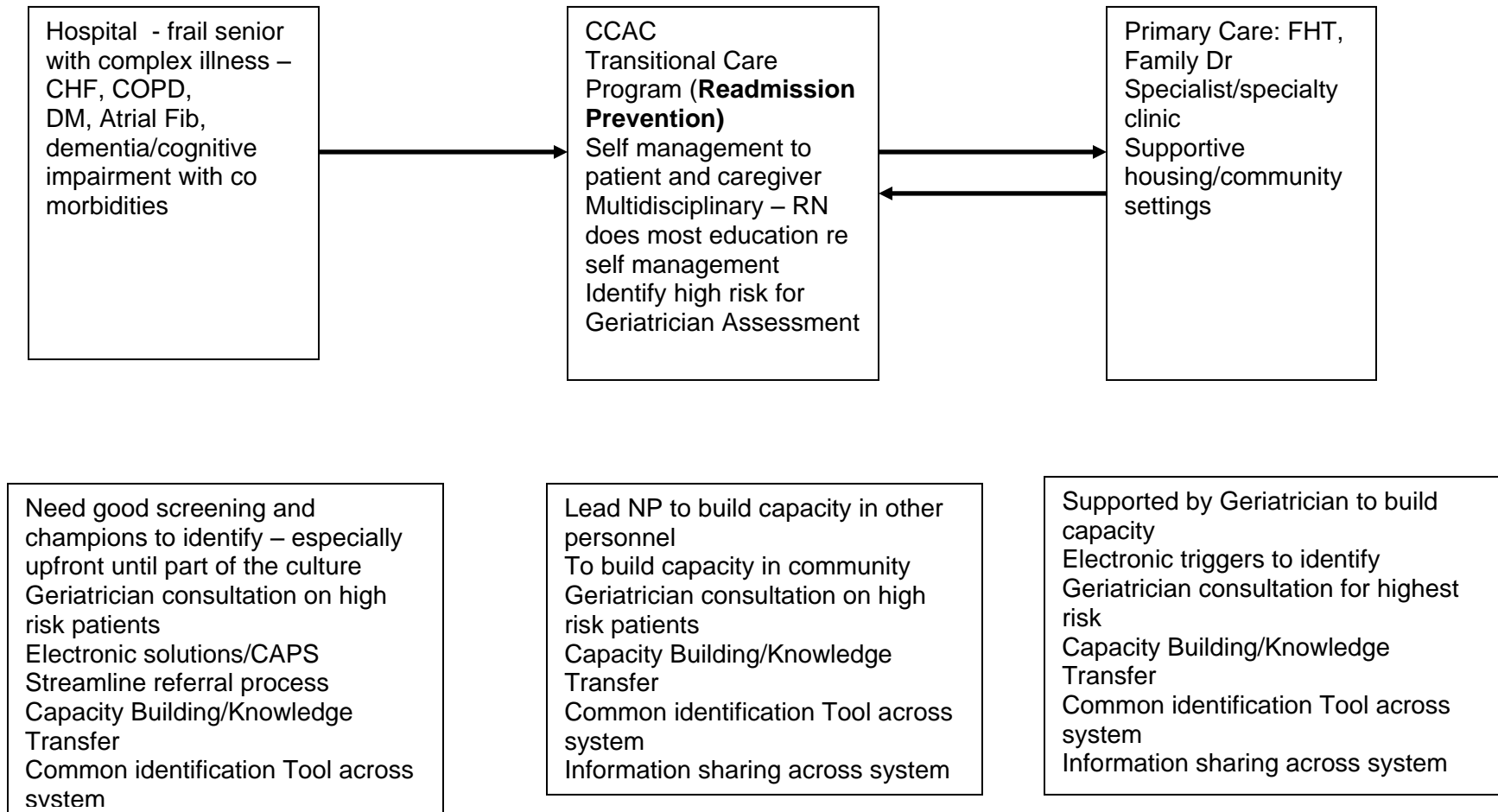
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PAG Name Transitional Care		PAG Facilitator Dr. George Heckman	
Component of service delivery model	Services associated with this component of the model	Clinical and non-clinical interdependencies (e.g., DI, lab, other programs/services, other PAGs)	Linkages to community services
Non-acute Hospital Care			
Post-Hospital Care	NP assess in the hospital and in the community CCAC. Contracting out as required to Physio to help senior improve independence at home		Pharmacy home visit or med review program
Community-based Acute Care			
Community-based Non-Acute Care	CCAC and NP – teaching self management , monitoring of symptoms, strategies to circumvent exacerbation Clinic and in home where appropriate NP could build capacity of other personnel e.g. RNs Education to non regulated personnel in client's home Case finding Multidisciplinary RN complete teaching, NP LHIN wide - lead building capacity Support to primary care Services developed in conjunction with clients/families, their goals and self management needs – Client centred not service centred Flexible duration of service e.g. longer for those with hidden cognitive impairment, System navigation	Supportive housing project or wellness centres Community Home to Stay programs CCAC attachments to supportive housing settings. Primary Care Geriatrician Interdependencies with informal and formal systems of support – consistency of approach CHCs for Francophone, aboriginal population for shared service delivery	Potential Enhancement – linkage to LTC NPs to manage in the LTCH Pharmacy home visit or med review program Heart Failure clinics/diabetes programs Academic linkages to maintain evidence based practice End of Life Care Primary care, hospitals

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PAG Name Transitional Care		PAG Facilitator Dr. George Heckman	
Component of service delivery model	Services associated with this component of the model	Clinical and non-clinical interdependencies (e.g., DI, lab, other programs/services, other PAGs)	Linkages to community services
	Follows national heart failure guidelines Quality indicators – readmissions, ACOVE (quality indicators for frail seniors) Patients/families taught to self navigate the care continuum, use of care passport		

Diagram of Ideal Service Delivery



Template #4. Assess and Describe the PAG service delivery model using the HNHB LHIN Criteria

PAG Name: Transitional Care		
Domain	Criteria	Assessment Description
Strategic Fit	Alignment with LHIN priorities for health improvement	ALC alleviation DM using CDM model as part of optimal management of co-morbidities or primary index condition Emergency Department Diversion CCAC able to service rural communities Could use e-health solutions
	Alignment with trends in health care needs and system transformation	Primary care reform Addresses growing senior, frail population Integrated approach LHIN wide access (not limited by catchment area) Shorter Hospital LOS – shift to community Continuity of care Holistic Self efficacy/self management approach Capacity building Strategic partnerships
Population Health	Health status (clinical outcomes & QOL)	Reduced hospitalizations and shorter LOS Reduce risk of adverse events Increased self management skills
	Prevalence	Will reduce prevalence of hospital admissions and acute decompensation of chronic illness in frail seniors
	Health promotion & disease prevention	Addresses secondary prevention

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PAG Name: Transitional Care		
Domain	Criteria	Assessment Description
System Values	Client-focus	Involves client in their own care Flexibility – tailored – duration, teaching etc to meet client need Consideration of linkages with CHCs re: populations – cultural and linguistic minorities Flexibility – initially focused on CHF but can later consider including other populations
	Partnerships	Reduce duplication CHCs, Other community partners such Alzheimers – First Link, Hospitals, CCAC, primary care,
	Community Engagement	Want to engage with Hamilton Council of Aging and other groups to keep consumer/patient focused Satisfaction surveys completed in pilot – feedback received
	Innovation	Evidence based Could include telehealth technology in transitional model
	Equity	Can be LHIN wide – not reliant upon patient transportation Can be facilitated by e-health
	Efficiency (operational)	Reduced costs Move to training nurses rather than using NPs
System Performance	Access	Can be LHIN wide – not reliant upon patient transportation Portable across LHIN – common approach

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PAG Name: Transitional Care		
Domain	Criteria	Assessment Description
	Quality	Best practice established by local evidence and national guidelines, as well as randomized controlled trials Local evidence from pilot that clients' experience very high satisfaction and improvement in self care knowledge
	Sustainability	Reduced costs so should pay for itself Move to training nurses rather than using NPs Capacity building in primary care Builds on current infrastructure, Integration with existing delivery systems Future training for health care professionals
	Integration	By definition; supports continuity care across the system. Essential core nature of the intervention.

Template #5: Description of Pre-requisites, Enablers and Challenges to Implementation:

Category	Pre-requisites	Enablers	Challenges
Policy/legislation	Appropriate funding levels	Supported by national policy re: Chronic Disease Management for Heart Disease “Canadian Heart Health Strategy Action Plan”	
Resources (e.g., human, fiscal, capital, etc.)	Human Resource investment Funding model for Geriatrician Consultation e.g. clinic space and supporting resources Need family physician	Using rich RAI HC data to risk stratifying Care Connectors Sharing of electronic care passport eg. Memory sticks	Limited clinic space for Geriatrician clinics Long waiting lists for Geriatricians No family physician
Community readiness	Community champions to promote uptake of new service Seniors Education to target the at risk population	CCAC support already in place for many of these individuals Linkages with retirement homes and supportive housing settings	Fear from some seniors – perception that it may complicate their care Support from family medicine
Services	Community Based Geriatrician consults e.g. CCAC branches, other Community Agencies. Co location agreements	Supporting infrastructure already in place re; hospital, primary care, CCAC, geriatric consults	
Partnerships/linkages	Hospitals need to invest in what happens in the community after patient discharge.	CCAC has established linkages with FHTs and Hospitals	Hospitals need to invest in what happens in the community after patient discharge