

Transitional Services Program Strategic Directions 2010-2013

Improving Flow and Transitions Across the
Continuum of Care

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Executive Summary

The Mississauga Halton Local Health Integration Network (MH LHIN) Transitional Services Strategic Plan sets out a vision and road map for the implementation for the redesign of Transitional Services across the continuum of care.

“Transitional Services” refers to the need to re-design:

- ❖ Over 300 complex continuing care beds operated by all hospitals in the Mississauga Halton LHIN at six (6) sites
- ❖ Specialized programming to be created in two (2) to three (3) LTC Homes in the next one to two years and,
- ❖ Intensive home care services provided by the Mississauga Halton Community Care Access Centre.

A Regional Transitional Service Framework has been developed to guide the implementation of the strategy. This strategy identifies the top nine (9) priorities and associated actions that the MH LHIN and its service providers will focus on over the next three (3) years, in efforts to provide all residents of the MH LHIN access to high quality standardized, evidence based transitional care in the most appropriate setting to meet their ongoing health care needs.

Two key overarching strategies are recommended that have the potential to transform the manner in which health care services are provided within the MH LHIN. A continued system wide acuity shift to the least intensive service setting and the transformation of current transitional care programs to short term goal oriented care with the goal to return home versus that of a permanent destination. This transformation will significantly increase capacity and flow within existing transitional care beds with the resultant reductions in both Alternate Level of Care days and acute care length of stays for people aged seventy-five (75) years and older; unplanned readmissions and institutionalization rates. Two critical factors to success have been identified; the adoption of a “Home First” philosophy with a target of eighty percent (80%) of patients being discharged home from Transitional Services as well as the creation of capacity within the Long Term Care (LTC) Home sector to accept residents with complex health care needs requiring a permanent home.

The strategy was developed in collaboration with the MH LHIN Transitional Care Work Group with consultation and feedback from the three (3) participating hospital Chief Executive Officers and their executive teams. The best available research evidence and existing experience from international, national and provincial sources was utilized to develop the new model and strategy.

It is recommended that the implementation of this strategy be managed within three (3) high level phases.

Phase 1 (January, 2010 – March 31, 2010)

- Realign existing complex continuing care beds to create a fourteen(14) to twenty four(24) regional Specialized Behaviour Unit at Trillium Health Care
- Confirmation of lead agency and program leadership
- Development of budget detailed implementation plan
 - Implementation Plan – funding, staffing models, program standards, outcomes, etc

- Demand, simulation modelling to determine appropriate system capacity and targets to support optimal system flow
- External review of long stay complex continuing care clients
- Identify siting for additional Restore programs
- Engage LTC Providers and CCAC as key stakeholders

Phase 2 (April 2010 – March 2011)

- Execution and implementation of the plan
- Implement LTC Specialized Programs and increased Restore capacity

Phase 3 (March 2011-2012)

- Implementation of Hospital Based – Specialized Transitional Programs
- Implementation of Hospital Based – Core Programs

The detailed recommendations for action are summarized as follows:

Recommendation 1: The MH LHIN adopts the proposed Transitional Care Services Framework, including the program definitions and goals, as developed by the Transitional Care Work Group.

- Develop a budget and implementation plan to guide the redesign of existing complex continuing care, slow stream rehabilitation, Restore, Convalescent Care and LTC beds.
- Realign existing complex continuing care beds to create a 14 – 24 Regional Specialized Behaviour Unit at THC in 2009/10.
- Design and siting of Regional Specialized Programs.
- All specialized programs and core palliative care programs to be developed with the input of specialized providers from across the MH LHIN, i.e. Peel Halton ABI Service, Respiratory , geriatric and psycho geriatric specialists, West Park, etc.

Recommendation 2: Designate a lead organization to assume accountability for the development and implementation of the Regional Transitional Services Program.

- Develop an implementation accountability and authority framework.
- Create a regional steering committee to oversee implementation.
- Designate an administrative and medical lead with the accountability to refine and implement the proposed transitional service model with the MH LHIN.
- Engage external experts as required e.g. Providence Health Care.

Recommendation 3: Develop regional standards to support the design and implementation of transitional services to ensure equitable access.

- The Medworxx tool will be used to assist in identifying appropriate admissions and discharges to transitional care programs.
- Only patients who meet the eligibility criteria will be admitted to Transitional Services Programs.
- Develop regional admission and discharge criteria for all Transitional Service Programs (screening tools, etc).
- Consolidate the Convalescent Care program into the Restore program and develop regional standards which include expanded patient eligibility criteria.

- Commission an external audit team to review all long stay patients in a complex continuing care beds to identify barriers to discharge.
- Explore the opportunity to relocate long stay complex continuing care patients who are appropriate for LTC.

Recommendation 4: Develop structures and process to ensure appropriate system flow to and from all transitional services.

- Develop processes and targets to support the smooth transition of patients between settings.
- Ensure that discharge planning is integrated across the continuum of transitional services.
- Review current hospital charting and documentation policies and procedures to support transitions between acute care and hospital based transitional programs.
- Identify designated staff in each site to be “Transitional Admission Coordinators.”

Recommendation 5: Develop and implement a human resource strategy to support the implementation of transitional care.

- Education and training of all current transitional care service providers on the new model of care.
- Education for all staff and physicians on the new model of care to support case finding.
- Recruitment of staff with the appropriate skill mix.
- Recruitment of staff and physicians with specialized training (geriatrics, palliative, rehabilitation, etc).
- Ensure the physician compensation model is adequate to support the shift to a higher acuity patient.

Recommendation 6: Develop a performance management and monitoring framework to assess clinical and system success.

- Develop regional staffing and funding models for all transitional services.
- Develop outcome and efficiency indicators with clearly identified targets for all programs and processes.
- Develop a process to provide reports and indicators for individual programs, i.e. palliative, general internal medicine, etc.

Recommendation 7: Ensure appropriate transitional bed capacity is available to achieve the vision and goal of the proposed transitional services model.

- Develop a system demand model to determine the appropriate transitional bed capacity required to achieve improved patient outcomes and optimal system flow.
- Realign and consolidate the existing complement of complex continuing care and slow stream rehab beds to support the implementation of the proposed specialized transitional service model.
- Increase access to Restore beds within all MHLHIN communities by increasing the number beds.
- Temporary Restore beds/units may need to be created with existing complex continuing care beds while LTC capacity is developed to support patient flow.
- Develop and implement specialized LTC programs to support full implementation of the transitional services model.

Recommendation 8: *Develop a communication plan to educate staff, physicians and the public about the new program and the changes it will bring to the health care system.*

- Develop a strategy to “rebrand” complex continuing care as the new “transitional care.”
- Develop a strategy to emphasize the shift in transitional care to specialized programs aimed at a higher acuity patient with complex health conditions, with the goal of discharging patients home.

Recommendation 9: *The MH LHIN explores the opportunity to expand transitional care to include ambulatory and community based care in the future.*

Introduction

There is growing recognition in developed countries worldwide that many patients in hospital do not require the intensity of care of an acute care hospital but cannot be cared for safely in the community and therefore need a level of care that is between acute hospital care and community care. This level of care is often referred to as “Transitional Care.” The need for transitional care is attributed to an aging population characterized by chronic disease and disabilities whose needs are multifaceted and complex. Transitional care has gained prominence as an important component of the health system and an appropriate model of care. Properly developed and implemented transitional care will enhance appropriateness and quality of care in addition to more effective use of hospital and long term care capacity by establishing new ways of working.

In September 2007 the Mississauga Halton Local Health Integration Network (MH LHIN) undertook a system level review of appropriate levels of care across the health care continuum in order to address increasing rates of Alternate Level of Care (ALC) patients utilizing acute care hospital beds. The review identified that the number of patients occupying “inappropriate” beds across the continuum of care has been steadily increasing. Complex continuing care beds are occupied with patients waiting for Long Term Care placement and Long Term Care Facilities report housing residents who they believe could be safely cared for in Supportive Housing settings etc. In a region where acute care bed capacity is at a premium, “this system ALC” further reduces the capacity of hospitals to meet the increasing demands driven by a growing and aging population. The report “Leading the Way – Addressing the Appropriate Level of Care Challenge in Mississauga Halton LHIN ” (May 2008) made a number of system level recommendations to ensure appropriateness and optimal flow across the continuum of care, one of the most notable recommendations being to redesign “Transitional Services.” Transitional services included complex continuing care, slow stream rehabilitation convalescent care and the Restore program. The area that presented the largest opportunity for redesign was the complex continuing care program which reported the highest ALC rate of 36%. (February 8, 2008). Inappropriate use of post acute or transitional care beds has a significant impact on patient flow and acute care capacity.

In efforts to improve flow and ultimately improve appropriate use of health care resources across the continuum, a review and redesign of post acute services within the MH LHIN was initiated in May 2009. The goal of the review was to develop a Transitional Service Model based on leading practice models and innovative strategies and solutions to increase acute care capacity while improving the overall experience of the individual and their family. In particular, this project seeks to identify how transitional services can function more effectively within an integrated health system model. It seeks to provide strategic vision and a context for policy development and regional service provision.

The objectives of the project were:

- To maximize the available acute care capacity and system flow by developing a MH LHIN program model for Transitional Services;
- To recommend a Transitional Service model based on leading practice models and innovative strategies and solutions to increase acute care capacity;

- To define the population appropriate for all levels of Transitional Services;
- To recommend the appropriate mix, number of beds and location for Transitional Services;
- To ensure that patients no longer requiring acute care are transitioned quickly and compassionately to the most appropriate level of transitional care based on their individual needs and program criteria.

1.0 Methodology

The project was broadly divided into three phases:

Phase 1: *Review of the Evidence*: A national and international literature review was undertaken.

Phase 2: *Current State Review*: a review of the structure, operation and utilization of the existing transitional services provided within the MH LHIN.

Phase 3: *Strategic Framework*: the development of a Regional Transitional Service Framework. Three service options were developed for consideration to guide the strategic directions for transitional service development across the MH LHIN.

A Work Group, chaired by the MH LHIN ALC Strategy Leader and supported by an external consultant, guided the project. A planning session was held with senior leaders and work group members from across the MH LHIN to develop the vision and guiding principles to support the work group in the development of the new model. The following principles were selected:

- Shift to a transitional model versus permanent destination
- Standardized Practice – clinical assessment tools, eligibility and discharge
- Ensure adequate medical support
- Individuals will be in the least intensive setting to meet their needs
- Appropriate clients – appropriate setting (use LTC beds for LTC residents)
- Knowledgeable staff to meet the needs of the population
- Balance critical mass, special programs and closer to home
- Explore partnerships for specialized models
- Maximize current capacity
- All complex continuing care grandfathered patients will be reviewed for eligibility for Long Term Care.

The review focused primary on complex continuing care, slow stream rehabilitation (a subset of complex continuing care), Restore and the convalescent care program models and their effectiveness. Services provided through the Community Care Access Centre (other than Case Management provided in current transitional service programs), acute care services (including acute rehab), long term care and community support services were out of scope for this project.

2.0 Review of the Evidence

A national and international literature review of transitional care service models was undertaken. This review of the local and international literature examines the definition, demand, provision and effectiveness of transitional services across the continuum of care. A site visit to one of the foremost local providers of Complex Continuing Care Services, Providence Health Care in Toronto, Ontario was conducted to examine a leading practice model in the provision of transitional care.

2.1 Definitions and Populations

There is no one commonly accepted definition of “Transitional Care.” This grouping of services is often referred to in the literature as subacute, transitional, post acute, skilled nursing, convalescent care, interim care and intermediate care. Although there is no consensus in the literature on a definition for transitional or subacute care there is agreement that this level of care will play an important and growing role in supporting health systems to respond to the demand of an aging population. In general, transitional care is a level of care for patients with moderate to low acuity who have some acute care needs but do not require the intensity of services provided in a traditional acute care hospital setting. Subacute care is given for a limited time (several days to several months) until a specific goal is accomplished, such as stabilizing a condition or completing a predetermined treatment course at such time the patient is discharged home or to a less intensive service setting.

“Subacute Care” is the terminology most frequently utilized in the literature to describe this group of services and will be used interchangeably with “Transitional Care” throughout the literature review. The concept of subacute care has developed in the last decade in response to the need to decrease the length of hospital stay and the recognition that many hospitalized seniors with acute episodic complex health conditions have better outcomes when there is an early focus on functional rehabilitation.¹ For this reason sub-acute care is often identified as transitional care. Transitional care emerged in the United States starting in the mid-1980s in response to a changing climate for health care delivery and favourable Medicare payment schemes.² It is now a well developed level of care that falls between acute and long term care.³ In the United Kingdom, it is estimated that up to one quarter of acute admissions of older persons require this type of service following the acute phase of hospitalization.⁴

The International Subacute Health Care Association defines subacute care as:

“A comprehensive, cost-effective and outcome oriented approach to care for patients requiring short-term, complex medical and or rehabilitation interventions provided by a physician directed interdisciplinary, professional team. Subacute services should be administered through defined programs without regard to setting. Subacute programs typically are utilized as an

¹ Makowski TR, Maggard W, Morley JE. 2000. The Life Care Centre of St.Louis experience with subacute care. *Clinics in Geriatric Medicine* Vol 16(4):701-719

² Kathleen Griffin (ed). 1995. *Handbook of Subacute Care*. Gaithersburg, Maryland: Aspen Publishers, Inc.

³ Shu-Chuan Jennifer Yeh, Thomas T.H.Wan, Martha Neff-Smith. 2002. Subacute care in nursing homes. *JONA* 32 (7/8):369-370.

⁴ Korbin Liu, Kirsten J Black. Hospital-based and freestanding skilled nursing facilities: Any cause for differential Medicare payments? 2006. *Inquiry - Excellus Health Plan*; 40(1):94-104.

inpatient alternative to an acute hospital admission or an alternative to continued hospitalization, and may be a component of a vertically integrated health care system”.⁵

The following definition is approved jointly by the American Health Care Association, Washington, D.C., and the Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois.

“Subacute care is comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process. It is goal-oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a person's underlying long-term conditions and overall situation.”⁶

Primary Target Groups: Subacute patients nearly always have a baseline of functional and physical impairments as a result of pre-existing medical conditions and are typically older. Seniors are considered as the primary target group within a transitional service system and while, younger people who meet the criteria for transitional services are also eligible for services the system is dominated by older patients.

Service Settings: Subacute or transitional services are also commonly identified by the setting in which they are delivered. Subacute health services range from inpatient care in Long Term Care Facilities and in dedicated units within acute hospitals, to a variety of specialist outpatient clinics and home based services such as rehabilitation in the home. North American programs tend to focus on inpatient facility based programs while other jurisdictions such as Australia and the United Kingdom offer a range of transitional services across the continuum of care. The trend towards community and home based care is expanding the margins of the transitional subacute system and creating new challenges for subacute service delivery models.

Benchmarks

There are no standard benchmarks found in the literature as programs, legislation and policies vary across jurisdictions. Benchmarks that do exist tend to focus on length of stay and discharge disposition. One common theme found in the literature is the goal of transitional services is to support individuals to return home. There is little documented evidence to indicate the levels to which this goal is achieved. Discussions with Providence Health Care in Toronto and Health Authorities in Western Canada have indicated that most programs have targeted and achieved

⁵ Lewin-VHI, Inc. 1994. Subacute Care- A Review of the Literature. Prepared for Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services.

⁶ IBID

an eighty percent (80%) discharge home rate. Average length of stay for comparable programs is listed below.

ALOS	USA	British Columbia
General Medicine	10 – 40 Days	4 – 30 days
Rehabilitation(LTLD)		14 - 35 days
Palliative Care		ALOS 45 days
Specialized Unit (Vents)	LOS 25 days +	
RESTORE		4- 10 weeks (16 max)

Estimates of the cost of subacute care in the available literature range from \$200 per day to over \$900 per day⁷. It is very difficult to compare costs due to the variety of patient groups served, the different settings in which transitional services are provided and labour costs associated with different jurisdictions. For the purposes of comparison, complex continuing care rates throughout Ontario were obtained. Complex continuing care is provided in two main settings in Ontario; attached hospital units and stand alone facilities such as Providence Health Care and West Park in Toronto, which tend to provide specialized services at a high cost.

2.2 Transitional Care Program Models

A variety of program models exist and there is limited data in the literature about the best approach. Most programs are comprised of rehabilitation and medical programs ranging to programs with considerable specialization such as ventilator dependent and weaning programs, specialized infusion therapy, post surgical recovery and behaviour modification. Overall most transitional service models have the following common characteristics:

- A focus on functional improvement and the provision of short term goal oriented services by multi-disciplinary teams
- They consist of a number of programs of care organized around patient populations – functional vs. diagnosis
- They are generally classed as either medical or rehabilitative
- They are typically provided immediately after an acute care hospitalization, but can be an alternative to acute admission.
- They reflect the value of the least intrusive service option, characterized by a normalized environment (dress, meals, and other aspects of daily living), supporting independence and self-care.

⁷ Lewin-VHI, Inc. 1994. Subacute Care- A Review of the Literature. Prepared for Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services

- The programs are mainly provided as inpatient services in hospital or freestanding facilities such as skilled nursing facilities or in long term care and in some jurisdictions services are provided in ambulatory outpatient clinics or in community settings.

United States

The subacute care industry is well established in the U.S. and serves mainly geriatric patients with the following needs: medically complex, respiratory care, post surgery, rehabilitation, brain injury, cardiac recovery, IV therapy, oncology, and wound management. There are four types of subacute care services provided in the U.S.: transitional, general, chronic, and long-term transitional. The first, transitional subacute care, serves as a step-down level of care for post acute patients who have high medical monitoring and nursing care needs but who do not need the intensity of acute care. Transitional subacute care is a substitute for acute hospital days while other forms of subacute care are generally a substitute for hospital discharge placement. All programs are focused on the promotion of optimal functional independence at the time of discharge.⁸ In the U.S., settings offering subacute care include long term care hospitals, hospital-based skilled nursing facilities (SNF), freestanding SNFs. Each setting typically focuses on certain types of subacute care services. Long term care hospitals serve patients with complex and multi-system conditions that require inpatient care. Their patients stay twenty five (25) days or more and they have daily physician visits. In long-term care hospitals, the type of subacute care typically provided is long term transitional care. Hospital-based SNFs usually deliver transitional subacute care to allow the hospital to treat patients over a continuum of care. They are used as a “step down “unit from the acute hospital services. Freestanding SNFs provide general subacute care, such as rehabilitation, wound care, or IV therapy, and chronic subacute care, such as ventilators. Some also provide transitional subacute care.(3)

United Kingdom

In the United Kingdom, transitional subacute services are called “Intermediate Care “and have been widely introduced as part of the National Health Service’s - National Service Framework for Older People (2001) with the goal to provide lower cost more appropriate health care for older adults.⁹ “Intermediate care is a range of needs led, transitional and integrated services that are intended to maximize health gain and prevent unnecessary admission to an acute hospital bed, support timely discharge, reduce avoidable use of long term care and maximize independent living” These services are delivered in partnership between primary and secondary health care providers, local government services (social care) and the private sector.¹⁰ This comprehensive strategy aims to promote and maintain independence of older Britons while reducing hospital and long term care use. Many aspects of intermediate care overlap with the concept of subacute care. However, intermediate care is broader than the definition of subacute typically applied in the U.S. as there is a focus on admission avoidance through the provision of in home services. Intermediate care programs are diverse and are typically grouped into three types of services:

⁸ Kathleen M Griffin. 1998. Evolution of Transitional Care Settings: Past, Present, Future. AACN Clinical Issues; 9(3):398-408.

⁹ National Health Service. Older People's NSF Standards. www dh gov uk [2006 [cited 2006 Feb. 3]; Available from: URL:<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeoplesNSFStandards/fs/en>

¹⁰ Intermediate care strategy for Medway and Swale Summary of needs assessment phase, October 2003. Available from: http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/OlderpeoplesNSFstandards/DH_4002288

Admission Avoidance/Prevention

- Rapid Response Teams
- General Practitioner Nursing Home Beds

Post Acute Care

- In-Patient Nursing Beds (Nurse Led Units)
- Supported Discharge Schemes
- Hospital at Home
- Social Services Rehab – Residential Care

Pre or Post Acute

- Community Hospital
- Community Care Centre
- Hotel Beds and or Patient Hotels

The evolution of intermediate care as a concept rather than a specific type of service in the NHS has led to a very wide diversity of models based on local need making it difficult to determine the effectiveness of this ten year initiative.

Australia

The term “subacute” was introduced in Australia in 1992 to describe patients whose need for health care is predicted by their functional status, rather than their principal medical diagnosis. In Australia, subacute care encompasses palliative care, rehabilitation medicine, psycho-geriatrics and geriatric evaluation and management but not convalescent, respite, or long-term care.¹¹

Australia has also developed a category called “non acute” care which is described as “maintenance care” and provides respite and interim LTC. Similar to the US and the UK, Australia’s subacute care service was developed in response to increasing demands for acute care beds and overcrowded emergency departments. Services were initially offered in acute care inpatient units, but with the introduction of “Aged Care Packages” subacute care are increasingly being offered in ambulatory and community settings. In 2002, Victoria, developed a strategic framework to guide the development of its subacute care services which were previously fragmented with and delivered and developed by separate agencies in isolation from each other resulting in inequitable access across the region. The framework developed a common definition for subacute care and recommended the development of regional standards, benchmarks, funding and a performance management framework.

To better understand patient needs and costs of subacute care, Australia has developed a national classification for subacute and non-acute care- Australian National Sub-Acute and Non-Acute Patient Case mix Classification System, or AN-SNAP classification.

Canada

In Canada, the components and structure of subacute care programs vary across provinces and jurisdictions. Most commonly, health regions and hospitals have designated subacute units or beds within acute facilities. In Nova Scotia, subacute or “transitional” care units have been established within a number of hospitals. The Winnipeg Regional Health Authority is developing

¹¹ Sach and Associates. 2001. Subacute Services, Strategic Directions, Victoria. Australia Ministry of Health and Human Services.

subacute units within acute facilities. Similarly, in Saskatchewan, “transition” beds are being used for patients who are subacute and those who are awaiting an alternate level of care. In Calgary and Edmonton, auxiliary hospitals are used to serve subacute patients. In British Columbia subacute care is under the umbrella of acute care while transitional care units have been opened in residential care facilities and are considered community programs. Both services only accept patients who demonstrate a potential to improve and return home to independent living, with subacute accepting higher acuity clients. Vancouver Coastal Health Authority uses the InterQual Suite of tools to determine appropriateness for both levels of services.

Ontario

In Ontario, some subacute care is provided in acute facilities but there is no separate bed or data classification for these patients. The Ontario Health Services Restructuring Committee, (2000) did recommend the introduction of subacute care as a distinct service within Ontario hospitals as the report estimated that thirty to forty percent of acute care hospital days were deemed subacute. This recommendation was not adopted as The Ministry of Health and Long Term Care policy states that subacute care falls within the acute care continuum and does not require a separate category of beds with separate funding outside of the hospital’s global budget. The Ministry believes that to some degree subacute care is already being provided and will continue to be provided by hospitals through their global budget.¹² the closest service to subacute care in Ontario would be the complex continuing care programs and convalescent care provided in long term care homes which provides goal oriented short term convalescent care for patients who do not require an acute bed but not yet able to return home.

In Ontario, the term “complex continuing care” (CCC) is used interchangeably with “chronic care” complex continuing care provides continuing, medically complex and specialized services to both young and old, sometimes over extended periods of time. Complex continuing care is provided in hospitals for people who have long-term illnesses or disabilities typically requiring skilled, technology-based care not available at home or in long term care facilities. Complex continuing care provides patients with room, board and other necessities in addition to medical care and patients are charged a per diem rate similar to LTC. Complex continuing care is frequently confused with LTC as in the past it served has a permanent destination for many patients and charges perdiems. The role of complex continuing care has changed dramatically over the past five to ten years and is increasingly shifting towards an intermediate transitional model of care that is goal oriented and focused on functional improvement supporting patients to transition home or to an appropriate less intensive care setting. However, confusion between the role of complex continuing care and LTC continues to exist, this confusion has been further compounded by the introduction of “convalescent care” provided in long term care.

The Complex Continuing Care and Rehabilitation Provincial Leadership Council of the Ontario Hospital Association developed a discussion paper; “Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System” May 2006,

¹² Looking Back, Looking Forward A Legacy Report the Ontario Health Services Restructuring Commission (1996-2000).

that outlines a number of recommendations to transform the current service delivery model towards that of a transitional model of care consistent with national and international models.

Providence Health Care, Toronto Ontario

Providence Healthcare is a leading Toronto health care facility specializing in geriatric rehabilitation, assessment and treatment, complex continuing care, long term care and community outreach with a particular focus on addressing the medical, physical, spiritual and emotional needs of individuals with geriatric conditions. In response to requests from their acute care partners to accept patients sooner and at a higher acuity, Providence has transformed its complex continuing care program from a maintenance permanent destination focus to a specialized transitional post acute model focused on functional enhancement with the goal of returning clients home. Providence has set a target for 70% of clients to return home and has currently reached 68% in 2008.¹³ As reported by the Medical Director, Dr. Peter Nord, this number has increased to 75% of all clients discharged home. Providence has a well developed medical model with physicians on site three (3) times per week in order to support clients with increased acuity and complex medical needs. The organization has employed Lean Design and “Push Pull” techniques to assist in this transformation.

2.3 Determining Demand for Transitional Services

Many jurisdictions have grappled with the challenge of determining the need and demand for transitional services. Benchmarks have been developed in some jurisdictions but it is difficult to universally apply these as need and demand is heavily influenced by local and national health service delivery models, policies and funding. The benchmarks that are mentioned in the literature were used for planning purposes only and there was no mention as to whether the benchmarks were accurate and improved system flow. The literature also identified three (3) main projection methodologies in use internationally; projections with a focus on subacute care, projections with a focus on acute care which often included subacute utilization in the overall projections and projections of specific diseases or conditions influencing the demand for subacute care. The most common method used to estimate current or future need was benchmark ratios of beds to population. The following outlines a sampling of models and benchmarks found in the literature:

Australia- Subacute Inpatient Programs (2001)

Rehabilitation 3 beds/1000 70 years and over , Geriatric Evaluation and Management 205 beds/1000 70 years and over and Palliative Care beds 50 beds/1 million persons.¹⁴

Australia has recently begun to use the data collected from the national Sub-Acute and Non-Acute Patient Case mix Classification System to help determine need and demand. The data is further adjusted for age, sex and mortality rates applied against population projections. Many jurisdictions in Australia are also using evidence based utilization management tools such as InterQual to support the identification of patients who could benefit from subacute services.

¹³ Time to Shine, Providence Health Care Strategic Plan, 2009.

https://www.providence.on.ca/AboutUs/Documents/,DanaInfo=.apvdomhyp1nJ0319xtv5vyU--X10+A3_June%2017_09.pdf

¹⁴ Sach and Associates. 2001. Subacute Services, Strategic Directions, Victoria. Australia Ministry of Health and Human Services.

United Kingdom

There is no benchmark noted in the literature. The only mention of demand for this level of service is a paper that estimated up to one quarter of acute admissions of older persons would be appropriate for “intermediate care” following the acute phase of their hospitalization.¹⁵ York University developed a model that assumed intermediate care days would replace acute care bed days at a rate of 1.5 days for every 1 acute care day. This model was adopted by the NHS National Beds Inquiry project that predicts the future length of stay reductions for acute care out to 2019.¹⁶

United States

There is no standard benchmark used in the USA to determine need for subacute transitional care as the funding mechanisms vary significantly between states. Funding rather than need tends to drive demand and the development of this service within the US. There have been a number of reviews and studies conducted over the years in the US with the majority concluding that twenty (20) to forty (40) percent of current acute care inpatients could be cared for in a subacute level of care. The authors note that caution must be used in utilizing these statistics as the majority are based on past utilization and not necessarily predictive on need. This study recommends that disease specific estimates should be used to predict demand rather than historical utilization rates as most subacute units are disease specific.¹⁷

Kaiser Permanente, which provides integrated health care, has developed a benchmark to guide the development of acute and subacute capacity. Kaiser manages the acute part of their care with 193 bed days per 1000 population less than 65 years and 1031 bed days per 1000 population over 65 years. The acute care component of the Kaiser system is complemented by subacute care, expanded ambulatory and primary care services, chronic disease management strategies, self management models.

Canada

There are a number of different methods used across the country to determine the need and demand for subacute/transitional services. A number of models have been developed using Diagnostic Short List (groupings of similar ICD10 codes), while others have used utilization management tools such as InterQual to assist in this determination.

Ontario – Health Services Restructuring Report (May 2000)

The Health Services Restructuring Commission recommended a benchmark of:

Rehab 22.2/100,000 population

Subacute 13/100,000 population

¹⁵ Korbin Liu, Kirsten J Black. 2006. Hospital-based and freestanding skilled nursing facilities: Any cause for differential Medicare payments? *Inquiry - Excellus Health Plan* 2006; 40(1):94-104.

¹⁶ UK Department of Health. 2000. Shaping the future NHS: long term planning for hospitals and related services. Consultation document on the finding of The National Beds Inquiry – supporting analysis. London Department of Health

¹⁷ Lewin-VHI, Inc. 1994. Subacute Care- A Review of the Literature. Prepared for Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services.

British Columbia

Fraser Health Authority

The Fraser Health Authority used a combination of different models to determine the need for subacute services. They sorted all patients in hospital for greater than five (5) days by Diagnostic Short List (DSL) and then determined which DSL groupings would fit within each specific subacute program model. They also used the Ontario Health Services Restructuring benchmarks and both methods determined that Fraser Health required between 648 to 655 subacute care beds. This number did not include the transitional care beds which provide reactivation and convalescence care in LTCH's.¹⁸ On July 2009 Fraser Health Authority had 237 subacute care beds and 150 convalescent care beds.

Vancouver Health Authority

Similar to Fraser Health Authority, Vancouver Coastal Health Authority provides subacute care in most hospital sites and convalescent care in LTCH's. There is currently no bench mark for subacute care, but a benchmark of 1.6 to 1.8 beds/1000 65 years and over for convalescent care bed planning has been used. This benchmark is loosely based upon Calagay's target of 2.6 beds/1000 65 years and older.

¹⁸ Subacute Planning for Implementation (May - July 2002) A Report of the Subacute Steering Committee. Fraser Health Authority.

3.0 Current State Review

In order to determine the future need and design of transitional services within the MH LHIN, a review of current hospital-based complex continuing care, slow stream rehabilitation and long term care-based convalescent care and reactivation programs were reviewed. The review focused on current capacity, program standards, utilization, cost and outcomes. An inventory of services and utilization was completed by all providers in October 2009. (Refer to the MH LHIN Transitional Service Supplemental Report). A survey was also conducted with all transitional service providers in which they were requested to identify current gaps and opportunities for the redesign of this sector.

3.1 Current Transitional Capacity

	SSR	CCC	Palliative	Restore/ Convalescent	Other	Total	Future
HHS	23	33	20			76	64 by 2023/24
CVH	14	14			2 Respite 10 ALC	40	5
THC	14	194			12 TCU	220	
Post Inn				17		17	
MLC				26		26	
Total	48	241	20	43	24	379	448

Transitional Care Inventory – October 2009

When compared to other jurisdictions it would appear that the Mississauga Halton LHIN has sufficient transitional care bed capacity to meet current and future demands when compared to the evidence and leading practice in this area, assuming policies and legislation are equal.

3.2 Current Utilization and Cost

Transitional Care Utilization

	HHS	THC	CVH	Post Inn	MLC
ALOS	35-57 days	169-404 days	116	54	44
D/C Disposition					
Home	33%	19.3%	36%	78%	80%
Retirement	0%	1%	6%	0%	0%
LTCH	18%	8%	44%	6%	6%
Hosp	7%	18.6%	8%	11%	9%
Death	30%	48.6%	6%	0%	
LTC Rehab	9%	1%	0%	0%	
Other	6%	5%	0%	0%	
RESTORE/CC	0%	0%	0%	n/a	
Occupancy	94%	96%	94%	91%	83%
Hours Care/day	3.8 – 5.1	3.2 – 3.86	5.3	3.45	3.45
% ALC	31% - 50%	2 -7%	20 -25%	N/A	N/A

Data Source – DAD for hospital programs, self report from Convalescent Care and Restore Transitional Care Inventory – October 2009

The utilization data above indicates opportunities for improvement in length of stay and discharging patients home, when compared to the evidence and leading practice in this area.

Complex Continuing Care Cost Comparisons

	CVH	THC	HHS	West Park	St. Peter's	Providence	Runnymede	Grace	SOC
DC Per diem	\$436	\$258	\$368	\$390	\$318	\$314	\$350	\$301	\$357
DC per RRPD	\$423	\$263	\$339	\$ 339	\$298	\$320	\$323	\$311	\$316
CMI (OCDM)*	1.03	0.98	1.08	1.15	1.07	0.98	1.08	0.97	1.13
CMI (CIHI)**	1.03	0.99	1.08	1.15	1.07	1.03	1.09	0.97	1.14
% DC D&T	18.9%	6.7%	17.1%	17.8%	14.6%	22.7%	16.9%	13.4%	13.0%
% DC Food	6.8%	9.7%	9.1%	8.5%	9.8%	9.2%	11.2%	11.8%	10.0%

2008/09 OCDM Direct Care Cost Comparisons

3.3 Determining Future Demand

All of the MH LHIN hospitals are in the process of implementing the Medworxx Utilization Management Tool to support appropriate acute care utilization and flow. The tool has also been recently introduced into complex continuing care. Consistent with the literature, the utilization management tool was used to assist in determining future demand. A one day snapshot was conducted on all acute care medical, surgical and rehabilitation units currently using the Medworxx tool to determine if there are patients occupying acute care beds who may be appropriate for the redesigned “Transitional Care.” Medworxx identifies these patients as “Not Met” in that they did not meet the intensity of acute care criteria. The evidence has suggested that approximately 10% to 20% of days in this category could be cared for in “Transitional Care.”

Medworxx Review – May Not Require Hospitalization (Acute Care) Snapshot November 5, 2009

	% Days “Not Met”	% Days Ready For Discharge
Med/Surg		
THC	75.5%	53%
HHS	N/A	N/A
CVH	73%	39%
MHLHIN Total	56.8%	42.3%

THC – 4B, 5G, 6J, CVH 1B, 2B, 2C ONC, 3B Med, HHS – still in implementation

Medworxx Review – May Not Require Hospitalization (Rehab) Snapshot November 5, 2009

	% Days Not Met	% Days Ready For Discharge
Rehab		
THC	15.4%	5.7%
HHS	N/A	N/A
CVH	30%	6.3%
MHLHIN Total	17.2%	6.75%

HHS – still in implementation

A Medworxx snapshot of current patients occupying complex continuing care beds was also completed in efforts to identify “Not Met” days. As the Medworxx tool has just recently been introduced into complex continuing care, the reliability of the “Not Met” data was in question and subsequently not used. The data on existing clients and length of stay was deemed sufficiently accurate and was included in the review. Patients identified as “Ready for Discharge” (RFD) by Medworxx were also included.

**Medworxx Review – Complex Continuing Care
November 5, 2009**

	ALOS	Patients LOS > 60d	Patients LOS > 365d	Patients LOS > 2 yrs	Patients RFD	GF	LOS Range
THC	698	70%	47%	26%	27%	19	1-6700d
CVH	844	50%	32.5%	42.5%	42.5%	6	1-7386d
HHS	64	12%	3%	1%	N/A	0	1-2002d
Total	565d	53.7%	34.6%	22.6%	29.7%		

The complex continuing care snapshot data suggests that there are significant opportunities to improve access, utilization and flow within the existing compliment of beds with the adoption of a “Transitional Service Model,” particularly at Trillium Health Care and Credit Valley Hospital.

Although it is difficult to compare to other jurisdictions due to legislative and policy differences it would appear that the MH LHIN has sufficient transitional bed capacity to develop a transitional service model if access to and utilization of existing beds is redefined and focused on transition versus destination with a target of 80% discharged home from hospital based programs. In order to achieve this target, LTC redesign will need to be included in the overall strategy in order to support this shift.

3.4 Complex Continuing Care/Slow Stream Rehabilitation

A similar shift to that noted in the OHA “Optimizing Complex Continuing Care Report” is also taking place within the MH LHIN complex continuing care units. For the most part there has been a decided shift away from lighter care patients requiring a residential model of care to more medically complex patients many of whom require active rehabilitation. This trend has resulted in shorter lengths of stay in some facilities and increasing complexity as indicated by an increased Case Mix Index (CMI) in some facilities. As evidenced by the data above, hospitals are at varying stages of introducing this shift.

Three common programs appear to have emerged overtime with complex medical and slow stream rehabilitation programs offered at all sites with palliative care currently only offered in complex continuing care at Halton Health Care and Trillium Health Care sites. Credit Valley offers a respite program for community clients. Trillium Health Care has converted 12 complex continuing care beds into a Transitional Support Unit with a focus on short term goal oriented care, similar to the model proposed by the Transitional Care Work Group.

As the three hospitals continue to deal with increasing demand for acute care services, complex continuing care beds are under pressure to accept inappropriate patients in attempts to support patient flow and as a result they frequently have patients with a predetermined destination of LTC occupying a large proportion of beds. This practice does provide some temporary relief to each of the hospitals, however, in the long run it will negatively impact system flow as patients

are not provided with the opportunity for reactivation resulting in an increasing demand for LTC services. Trillium Health Care is the only hospital that no longer accepts patients waiting for LTC into its complex continuing care beds.

Access

Eligibility and access to complex continuing care and slow stream rehab beds/programs are currently determined by each hospital. Staffing and funding models also vary significantly between sites and organizations. The admission process has been streamlined in all sites and typically will respond within twenty four (24) hours to a new referral. Most organizations report that case finding is happening on a daily basis at acute care rounds. Trillium Health Care has developed a Process Flow Map for referral and admission to complex continuing care from acute care and there are no performance targets associated with the process map at this time.

Performance Management

Most organizations are monitoring health outcomes through the quarterly RAI submissions to the Ministry of Health and Long Term Care. Trillium Health Care has developed an extensive list of twenty-four (24) quality indicators that are being monitored. Utilization is monitored at the local site level, ALC being the only indicator currently reported to the MH LHIN on a regular basis. Both health outcome and system indicators are reporting on balanced score cards at most sites and there is currently no regional reporting for this service.

Utilization Management

All three (3) hospitals have recently implemented the Medworxx utilization management tool in all complex continuing care units. The plan is to use the Medworxx tool to improve utilization and to ensure that patients are receiving appropriate care in the most appropriate environment. Currently there are no LHIN utilization targets, such as length of stay or discharge disposition for complex continuing care.

Resident Councils

Currently only Credit Valley Hospital continues to hold resident councils for patients and families.

Medical Model

All three (3) hospitals have assigned Medical Directors for complex continuing care. The Medical Director functions are mainly administrative with general practitioners and hospitalists providing the direct clinical care. The hospitals have reported that physician visits range between one to two times per week, with palliative patients receiving the most support. All three (3) hospitals reported that if physician visits could be routinely increased to two (2) to three (3) times per week, similar to Providence Health Care, that they could support higher acuity patients.

Perdiems

All hospitals are currently charging perdiems to all complex continuing care clients regardless if the goal is to return home. There is varying practice between organizations on perdiems for slow stream rehabilitation and palliative patients, with no charge for fewer than 3 months length of stay.

3.5 Convalescent Care and Restore/Convalescent Care

Convalescent Care was introduced to Ontario in 2005, with the goal to introduce a new short stay program for patients needing time and support to regain functional capacity prior to returning home. This program differs from complex continuing care and slow stream rehabilitation in that it is provided in a long term care home and is governed under the Nursing Homes Act, Charitable Institutions Act, and Homes for the Aged and Rest Homes Act. Post Inn is the provider of convalescent care in the MH LHIN. The patient population tends to be mostly orthopaedic, fractures and individuals who require reconditioning post operatively after a long hospital stay.

The Restore program is a similar program to the provincial convalescent care program however it was designed to accept patients with stable but complex medical issues rather than the orthopaedic patient who is mainly admitted to Post Inn. Mississauga Life Care is the provider of this program in the MH LHIN.

Both programs currently only admit patients who are deemed most likely to go home. The Convalescent Program does not accept patients who's discharge destination is unclear or is most likely LTC.

3.6 Provider Consultation

Consultation for the development of the new model was solicited through the MH LHIN Transitional Services Work Group as well as a survey of current transitional service providers, complex continuing care, slow stream rehabilitation, convalescent care and Restore (Refer to the MHLHIN Transitional Services Supplemental Report). The key themes identified in the survey are indicated below:

- The need to enhance capacity for transitional services
- Ensure specialist medical support is available for all programs
- Ensure a highly trained workforce is in place
- Standardize admission and discharge criteria across the LHIN
- Develop specialized programs to meet the needs of the post acute population
- Development of clearly defined program streams and transitions between programs
- Centralize the waiting list for all internal referrals to slow stream rehab and complex continuing care.

4.0 Transitional Service Strategy Development

The MH LHIN Transitional Services Work Group was engaged in six (6) planning sessions to guide the direction of the new transitional service model for the MH LHIN. The sessions focused on the development of a vision and key criteria for the development of the regional model that would be forwarded to senior executives within the LHIN. The Work Group was tasked with the following deliverables:

- Finalize a definition of transitional care and the component programs, including physician coverage;
- Reach agreement on targeted populations and programs;
- Identify the benefits and value of implementing transitional care and expected outcomes;
- Identify the risks, and issues that need to be addressed to achieve the benefits;
- Identify the system requirements and appropriate locations for transitional care programs for non-acute patients and patients waiting for facility placement;
- Identify the need and demand for transitional services (# beds);
- Develop a regional integrated access process for transitional services and,
- Collect resource material on operational models for transitional programs in various locations.

4.1 Transitional Services Vision

The work group envisions a program that will:

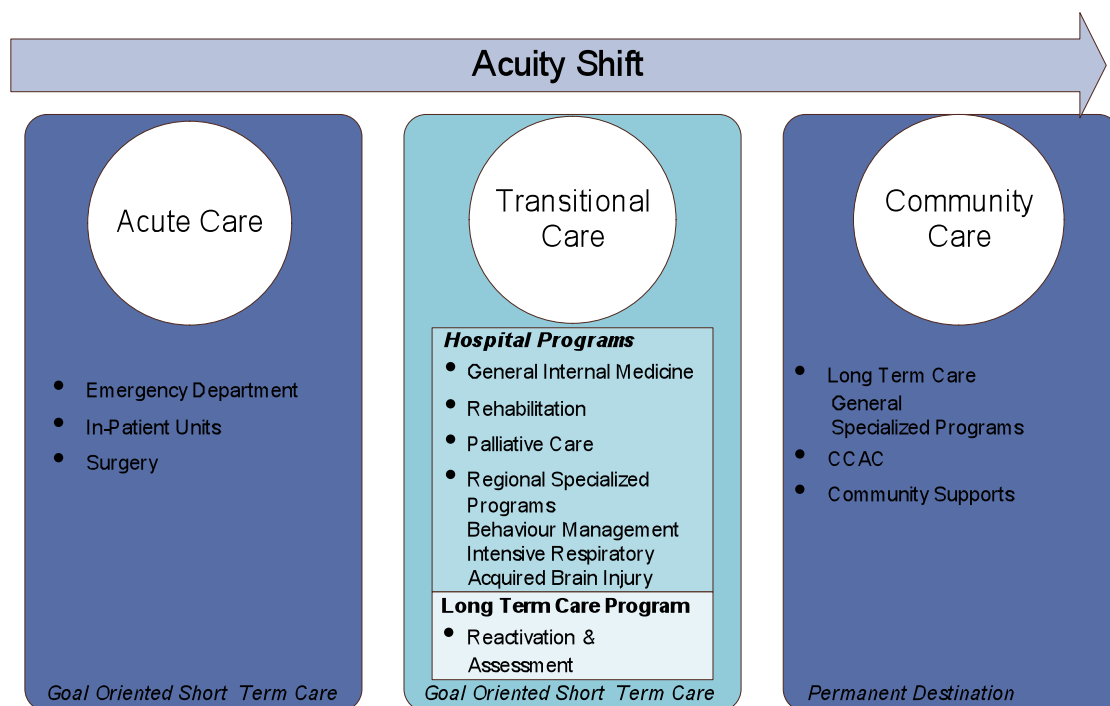
“Provide a range of goal oriented transitional care services in designated care settings that will offer a range of integrated services focused on maximizing independence and transitioning individuals home or to the least intensive service setting.”

“Services will be delivered in a coordinated and integrated manner that provides the appropriate care and decision making in the most appropriate setting to optimize optimal system flow”

4.2 MH LHIN Transitional Service Program Framework

A Regional Transitional Services Framework (Figure 1) was developed which reflects the role of “Transitional Services” in an integrated continuum of care and the system shift that will be required to achieve the expected outcomes of the new model. The redesigned “Transitional Services Program” will accept patients with higher acuity short term medical, rehabilitation and end of life care needs as well as patients requiring specialized care. It is envisioned that many of these patients are currently occupying acute care beds and that the shift to transitional care will increase access and capacity within acute care. Critical to the success of the new model will be a redesigned LTC sector that is able to accept the higher acuity patient currently residing in complex continuing care who requires care and a permanent home. It is anticipated that the framework will guide the development and implementation of transitional services over the next three (3) to five (5) years within the MHLHIN.

Figure 1 MH LHIN Transitional Services Framework



4.3 Transitional Care Service Delivery Model and Flow

The Work Group created three (3) conceptual service delivery/patient flow models based upon leading practice and the guiding principals developed during the May 2009 planning session with senior leaders. Conceptual Model C (Figure 2) was selected as it was felt to best meet the criteria and vision and supported integration and enhancement of the Long Term Care sector (Refer to the MH LHIN Transitional Services Supplemental Report for all three models).

The model was developed based upon the following planning assumptions:

- “Home First” is the preferred option for all patients receiving acute care and transitional services;
- Transitional care will provide short term goal oriented care – not a permanent destination;
- Decisions for permanent long term care placement will be made in the most appropriate setting;
- There is sufficient complex continuing care capacity to support a new model of care;
- There will be an increase in the number of individuals returning home to the community; versus going to LTC, therefore increasing the capacity and flow through of Transitional Care beds;
- The redesign of Transitional Services will be done within existing resources and,
- LTC will accept residents with medically complex health needs requiring long term housing and care.

Transitional services within the MH LHIN will encompass a broad category of time limited goal-oriented programs for patients with complex medical, functional and end of life care needs who

do not require the intensity and range of services of an acute care hospital but who cannot return home. Transitional services will be a distinct comprehensive inpatient program designed to enhance a patient's quality of life and or improve their functional status in order to safely return patients to the community or transition them to a less intensive level of care.

Transitional services will provide the following core functions:

- Clinical investigation, stabilization and treatment of multiple pathologies;
- Rehabilitation, treatment goal is to improve the functional status of a patient with an impairment or disability;
- Palliation and end of life care, and
- Reactivation and convalescence.

Transitional services will serve a variety of populations, however, consistent with the literature, it is expected that a significant proportion of patients seen will be elderly.

The MHLHIN will offer two streams of Transitional Care Services:

Hospital Based Transitional Services Program

Core Service Stream – Provided in all MH LHIN Communities

- General Internal Medicine - clinical investigation, stabilization and treatment of multiple complex health conditions;
- Rehabilitation - Long Term Long Duration (LTLD) to improve the functional status of a patient with an impairment and or disability, and
- Palliation and end of life care.

Regional Specialized Services Stream- Regional Clusters with Regional Access

- Regional services for specialized populations with sufficient critical mass to provide high quality goal oriented care – Behaviour Management, Intensive Respiratory and Acquired Brain Injury.
- Specialized services will provide the basic functions of the “Core Service Stream” to specialized populations
- Services may be provided at only one or two sites within the MH LHIN

Long Term Care Based – Transitional Services Program

RESTORE Program – Provided in all MH LHIN Communities

- Reactivation and functional enhancement
- Convalescence from an acute illness
- Assessment for permanent destination

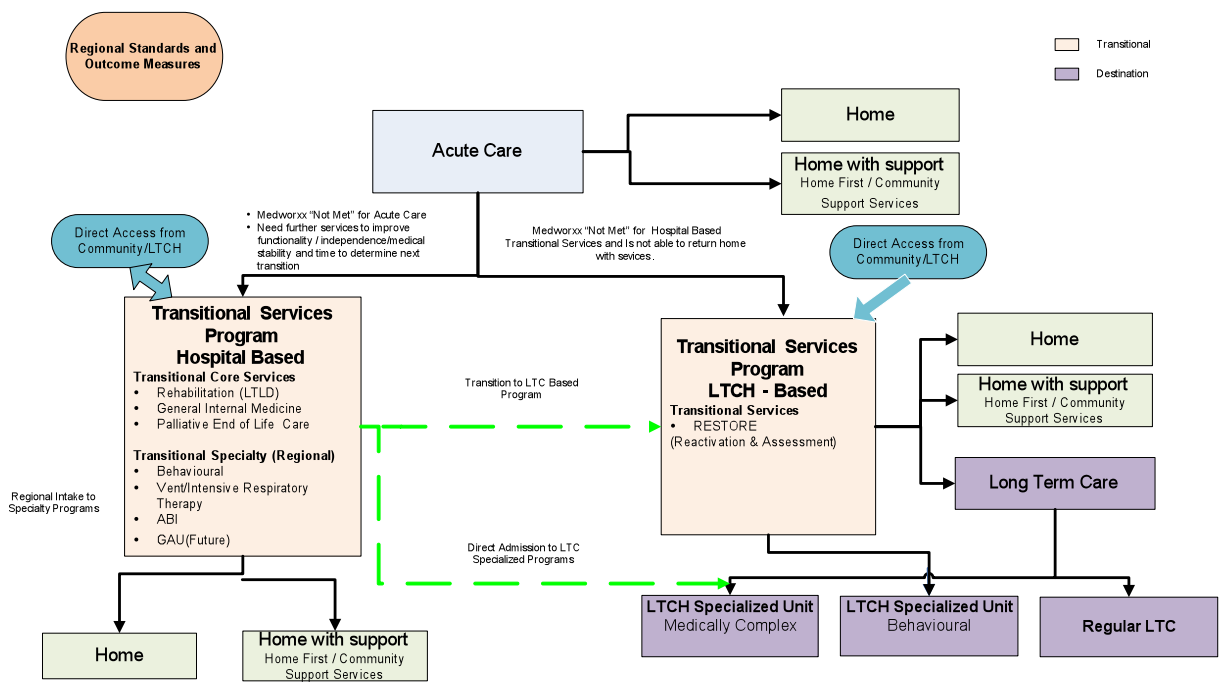
The Working Group has recommended that existing complex continuing care and slow stream rehabilitation programs be redesigned and renamed as “Transitional Service Programs.” The new hospital based programs will accept a higher acuity patient into the “Core Service” stream than is currently accepted into complex continuing care and the goals of care will be time limited and

focused on transitions versus permanent destination. The creation of “Specialized Programs” within the hospital based program will increase acute care bed capacity, as currently these populations are housed in acute care beds for extended periods of time. Another key theme in the new model will be that patients must meet admission criteria and patients that are assessed and waiting for a LTC bed will not be eligible for hospital based transitional services.

The model was also designed with the long term vision of shifting decision making on Long Term Care as a final destination away from the acute care sector to a more appropriate sector with the expertise in this area, the Long Term Care Based Transitional Service Program. It is recognized that this vision will evolve over time and that interim strategies will be required while the LTC sector is redesigned and able to meet this need.

The Long Term Care Based – Transitional Service Program will consolidate the Restore and Convalescent Care Programs under one program model and expand current eligibility criteria to include individuals whose final destination may be LTC in efforts to support the new vision. Figure 2 depicts the proposed system flow based upon the new program goals and admission criteria.

Figure 2: MH LHIN Transitional Services Flow



November 12, 2009

4.4 Transitional Service Program Model

HOSPITAL BASED - TRANSITIONAL SERVICE MODEL

A. CORE SERVICE STREAM

REHABILITATION - LONG TERM LONG DURATION (LTLD)

LTLD rehabilitation will be a core transitional service that primarily serves the frail elder population. It aims to improve function and or prevent deterioration of function where this has been lost from any cause, and to restore and maximise independence and quality of life. LTLD is a coordinated program provided by an interdisciplinary team of health professionals with geriatric expertise in assessment and treatment. LTLD rehabilitation includes assessment and treatment of the geriatric syndromes- including instability or falls, isolation or depression, cognitive impairment including delirium and dementia, incontinence, immobility, polypharmacy and inadequate nutrition. Disease or population specific wellness programs that provide health education, goal setting, behaviour change principles and practices to promote health and wellbeing of the individual and secondary prevention may also be offered.¹⁹

It is expected that patients entering LTLD will tolerate up to thirty (30) minutes of rehabilitation twice a day three (3) times per week. Goals of the program are to optimize client functioning and independence and identify potential for higher intensity rehabilitation and or return to the community. It is expected that patients will be admitted to the program within twenty-four (24) hours of referral²⁰ and the length of stay will be thirty (30) to one hundred and twenty (120) days.

Target Population/Eligibility

LTLD is suitable for individuals who have experienced a recent loss of function due to illness (i.e. recent severe acute multisystem illness, stroke, chronic deteriorating illness with acute exacerbation) or a complicated course in hospital requiring a slower-paced rehab program for a longer duration to maximize rehab potential.

The Medworxx utilization management tool will be utilized to determine appropriate admissions and discharges from the program along with the GTA Inpatient Rehab Triage Guidelines for Geriatric Patients. The key determining eligibility factor will be the patient's therapeutic activity tolerance level versus diagnostic categories.

GENERAL INTERNAL MEDICINE

The General Internal Medicine Program (GIM) will provide care for medically complex patients whose fluctuating medical conditions require an in-patient stay, active care management by specialized multi-disciplinary teams and access to regular onsite physician care and assessment. The initial plan of care is for patients to achieve medical stability and functional improvement under active interdisciplinary team management, including frequent medical supervision, and transition to a less intensive level of care and or return to their home environment whenever

¹⁹ Clarifying the Complexities of Inpatient Geriatric Rehab. February 2007. GTA Rehab Network

²⁰ IBID

possible. Though stable, the patient may require diagnostics or invasive procedures, but not intensive procedures requiring an acute level of care.

It is expected that the average length of stay will range from seven (7) days to sixty (60) days with an average length of stay twenty-eight (28) days for treatment of an active but stable medical condition. Some patients may have a longer length of stay up to one hundred and twenty (120) days while LTC capacity is developed to care for more complex patients. Patients may be admitted from an acute care inpatient unit, emergency department or as a direct admission from the community or LTCH.

Target Population/Eligibility

The target population for General Internal Medicine transitional services includes adults with fluctuating medical conditions and complex chronic illness with multiple co-morbidities requiring access to skilled nursing care and an inter-professional team for ongoing assessment, therapeutic treatment and functional improvement prior to going home or transitioning to a more appropriate setting.

Treatment Examples

- Dialysis patients
- G-tubes
- Traceheostomies
- Specialized wound care (stage 4 – 5)
- Vents (proposed)
- IV's (PICC's)
- Oxygen Therapy
- Blood transfusions
- Congestive heart failure
- Pain Control

Note: Care needs and clinical intensity will be dependent on the adjacencies of the transitional unit to an acute care hospital.

The Medworxx utilization management tool will be utilized to determine appropriate admissions and discharges from the program.

PALLIATIVE/END OF LIFE CARE

The aim of palliative end of life transitional care is to provide medical treatment and holistic care for patients who are unable to remain at home, or be discharged home from acute care due to care needs and or pain and symptom management issues. The goal of care is to promote a comfort approach rather than aggressive treatment. Some patients may be admitted to this service in order to stabilize the patient and or caregiver situation with a defined discharge in place. It is expected the average length of stay will be seven (7) to thirty (30) days with some patients staying up to six (6) months.

Target Population/Eligibility

- Individuals in the final stages of a life threatening illness
- Life expectancy ranges from several hours up to twelve (12) months duration
- Require the expertise of an on-site palliative care interdisciplinary team for the management of pain and other troubling issues
- Palliative Performance Scale greater than fifty (50)
- Direct care requirement >2hrs/day
- Physician care >2x/week
- Requires skilled nursing care and access to inter- professional team

Treatment Examples

- IV/PICC's
- Oxygen therapy
- Day Clinic – chemotherapy/radiation
- Wound care
- Blood transfusions
- Pain management – CADD Pumps
- Tracheotomy care
- Tube feeds
- Dialysis
- Hydration for pain and symptom management

The Medworxx utilization management tool will be utilized to determine appropriate admissions and discharges from the program. The Palliative Performance Scale can also be used to determine appropriateness for this service.

B. SPECIALIZED SERVICES STREAM

Specialized Transitional Services will be developed based upon patient need and critical mass. These programs will be provided on a regional basis with a centralized regional access and intake model.

BEHAVIOUR MANAGEMENT PROGRAM

The Behaviour Management Transitional Program proposes to provide a secure, specialized supportive treatment environment for persons with dementia or psychiatric diagnosis complicated by serious behavioural problems that are not responding to conventional treatment. The overall goal of the program is to stabilize and maximize one's abilities and help achieve a successful discharge back to a community setting at an appropriate level of care. The environmental setting and specific programs within this unit will offer both physical protection and supportive care to these patients with the goal to improve their quality of life with the minimum of isolation, physical restraint or chemical restraint. Services will be provided by an inter-disciplinary team of professionals with specialized training in behaviour management. Consultation to LTCH's will be provided to ensure continuity of care when the person returns home.

Admission can occur from home, LTCH or an acute care hospital with the MH LHIN. Admissions from Long Term Care will be for a forty-five (45) day assessment and treatment period with

expected return to the bed held in LTC. It is expected that the average length of stay will range from twelve (12) to sixteen (16) weeks.

Target Population/Eligibility

The target population includes individuals who have exhausted resources of a facility or acute care hospital because of unpredictable excessive disruptive behaviour. Individuals appropriate for this service have chronic progressive dementia or other organic brain syndromes, with significant behaviour problems that persist over time. Such a person would have received a complete medical and psychiatric assessment and have behavioural problems not responding to treatment. This may include physical or verbal aggression, agitated behaviour from whatever cause, social or sexual inappropriateness. The behaviour is often unpredictable with instances of acting out that cannot be anticipated. The behaviour is disruptive in other care settings or may put the person or others at risk. The key determining factor will be behaviour versus diagnostic categories. Behaviours may include verbally or physically responsive behaviours in relation to exit seeking, wandering, activities of daily living and social interaction, etc.

The diagnoses listed below are examples only.

- Age 18+ but focus on the older adult population
- Risk of harm to self or others
- Medium to severe cognitive impairment with physically/verbally abusive behaviours
- Confirmed Diagnosis
- Suicidal tendencies
- Korsikoffs
- PICKS
- Dual Diagnosis
- Dementia/territorial issues
- Huntington's

INTENSIVE RESPIRATORY THERAPY PROGRAM

This program will focus on supporting chronic ventilator dependent patients and those with chronic respiratory issues requiring high concentrations of oxygen and or complex tracheotomies with frequent suctioning and weaning. The respiratory program will adopt a rehabilitative approach to promote the highest possible functional level. Services will be provided by an interdisciplinary team of health care professionals who specialize in treatment of complex medical, physical, social and emotional problems associated with chronic respiratory disorders. The program will be goal orientated while caring for medically stable ventilated clients that require expert care and time to wean from the ventilator. It is recognized that there are some patients who will not be successfully weaned and may require longer term support in a transitional care while the LTC capacity is being developed to care for this population. Length of stay is expected to be between four (4) to twelve (12) weeks, although a few may require longer periods of time.

Target Population/Eligibility

- Patients requiring long term ventilation
- Patients needing weaning from chronic ventilators
- Severe chronic obstructive and/or other restrictive lung diseases

- Tracheostomies
- Continuous high flow (up to 50%) oxygen, continuous oxygen saturation monitoring
- Have daily care and medical needs that cannot be met at home, in a nursing home or through community-based services

Note – It is recommended that weaning units should be in or in close proximity to an acute care hospital and should allow easy access for readmission to the intensive care unit if required.

AQUIRED BRAIN INJURY PROGRAM

This program will provide individually targeted slow-stream rehabilitation and behaviour management services to people with an ABI who have the potential to achieve functional gains in their level of independence. The goal of the program will be to attain behavioural and functional stabilization with transition to a less intensive level of care and or return to their home environment whenever possible. As the number of patients requiring this service frequently fluctuates within the MH LHIN, it is proposed that this program would be housed in a separate section within the “LTLD” units with access to specialized interdisciplinary teams such as the Peel Halton Acquired Brain Injury Services (PHABIS) and the Behaviour Management Transitional Program.

Target Population/Eligibility

- Age 18+
- Diagnosis of acquired brain injury which occurred after birth and is not related to a congenital disorder, a developmental disability or a process that progressively damages the brain.
- Medically stable and require physical assistance with some or all activities of daily living, regular cueing or step-by-step instructions to complete ADLs.
- May have cognitive disturbances in the areas of memory, attention, judgment, insight, orientation and initiation.
- Mild to moderate behaviours, depression, mental health issues, anxiety or agitation. Behaviours may include verbal aggression, inappropriate responses, wandering with the intent of exploring rather than active exit seeking, demanding behaviours. Special medical needs such as chronic pain control, feeding tubes.

Given the complexity of cognitive and behavioural issues, it is recommended that individuals with ABI be accommodated in either semi-private or private rooms. Average length of stay is expected to be between four (4) to six (6) weeks.

LONG TERM CARE BASED – TRANSITIONAL SERVICE MODEL

Restore PROGRAM

The Restore Program supports individuals who no longer require the intensity of acute care or hospital based transitional services and who would benefit from restorative programming prior to their return home or to the most appropriate setting including LTC.

The program is able to support individuals for whom it is initially uncertain whether a return home is possible by providing a supportive appropriate location to determine if the individual’s capacities will allow them to return home with community services, a retirement setting, supports for daily living (SDL) or if LTC is the most appropriate destination. Patients requiring LTC placement after admission to Restore will be wait listed to their choice of facilities or if able, will

return home to wait for LTC. A stay within the Restore Program would allow the individual and their family additional time to consider the appropriateness of these options and provide them with discharge planning support to facilitate discharge from the program within the expected timeframe of six (6) to eight (8) weeks or once program goals have been met.

The goal of the Restore Program is to improve or stabilize the individual's ability to perform activities of daily living (ADLs), improve nutritional status, allow for the adoption to regular routines of a care setting and allow for more complex discharge planning.

Target Population/Eligibility

- Age 18+ but the majority will be frail elderly following acute care hospital stay at risk of LTC admission
- Medically stable
- Post surgical
- Disposition unclear at end of acute and hospital-based transitional phase. May be long term care or alternate with supports.
- Have reactivation potential for two or more ADL's
- Can be cared for with physician and or Nurse Practitioner visits of no more than one to two times per week
- Able to tolerate more than two hours of sitting

SPECIALIZED LONG TERM CARE

Specialized Long Term Care services were out of scope for this project but are seen as a key linkage and enabler to the success of the MH LHIN Transitional Services Model. The Ministry of Health and Long Term Care Services is currently developing a policy direction for the development of specialized LTC services. It is recommended that the MH LHIN work with Long Term Care providers to further develop this model of care.

AMBULATORY TRANSITIONAL SERVICES

In the literature, transitional/subacute programs encompass outpatient programs as well as inpatient beds. The proposed MH LHIN definition of transitional care and the associated planning for transitional programs only focuses on inpatient beds. In the future, the MH LHIN may wish to explore the expansion of subacute programs to include outpatient components.

4.5 Transitional Service Goals

The following goals for transitional services were developed and will be used as a basis for evaluating the program outcomes and effectiveness:

To improve health outcomes and quality of services for targeted populations, through

- Decreasing functional optimization
- Increasing the number of patients that return home and reduce requirements for readmission to acute care
- Decreasing the number of patients that require long term care immediately following an acute care episode

To improve health outcomes, through

- Maximized functional status with the provision of age appropriate care
- Improved quality of life
- Stabilization of medical status

To improve appropriateness of acute care resource use, through

- Decreasing average length of stay in acute care and improve system flow through
- Decreasing ALC days in acute and transitional care

To effectively use health care resources, through

- Achieving lower per diem costs related to a less costly acute care staffing model
- Achieving lower case costs related to more appropriate targeted care for people who, without these programs such as rehabilitation, would stay longer in acute care, and potentially require a higher level of ongoing contact with the health system.
- Improving access to services through the development of regional eligibility and standardized referral forms for all Transitional Services Core Programs and centralized regional access for Transitional Specialized Programs.

4.6 Execution Challenges

The adoption of the new ‘Transitional Services Model’ will require a tremendous shift in practice across the continuum of care. Executive Leadership support from all service provider agencies and the MH LHIN will be key to support the system transformation required to implement this new service model. The following areas will need to be addressed to support successful implementation:

Appropriate Capacity to Support Optimal Flow

The MHLHIN currently has three hundred and seventy-nine (379) beds designated for transitional care services. When comparing this to other jurisdictions and benchmarks it would appear that there is sufficient capacity to meet the LHIN’s current needs. The immediate challenge is that a majority of these beds are occupied by long stay patients who severely restrict flow through and utilization of these existing beds. In order to adopt the new model and improve patient flow within transitional care, these long stay patients must be relocated to a more appropriate care setting to meet their long term needs, such as LTC.

Long Term Care providers will require support to change their current model of care in order to accept a higher acuity client. Without this shift the full benefit of the new model will not be realized.

Restore capacity will also need to be reviewed and increased to support optimal flow and to attain the long term vision of supporting long term care decision making in the most appropriate setting. This function is currently performed mainly in acute or complex care beds for hospitalized seniors.

Medical Compensation

A new medical model with appropriate compensation will need to be developed to support the shift to higher acuity patients in hospital based transitional care programs.

Education – Public and Service Provider

Significant training and education will be required for all service providers regarding the increased patient acuity and shift from destination to transitional care. A change management plan will be critical to support this initiative.

Public Education will also play a key role in implementation. Individuals and family members will need to be educated in this new model of care, particularly when moving to Long Term Care Based Programs.

Physical Design

Physical upgrades may be required in existing complex continuing care faculties to accept the higher acuity patient, particularly the specialized programs. Oxygen and suctioning equipment will be required to support complex patients and secure units for the specialized behaviour programs are just an example of the areas that will need to be addressed.

LTC Placement Process

The current CCAC long term care assessment and placement process will need to be reviewed to ensure that it is in alignment with the new model and will support system flow. Reducing or delaying the need for LTC is a key goal of this redesign and CCAC plays a critical role in achieving this goal by ensuring that only clients who truly need LTC are placed on the wait list.

5.0 Recommendations

The MH LHIN health care provider organizations are eager to adopt this new “Transitional Services Model” and feel that they are well positioned to support this shift. The LHIN currently has a significant number of complex continuing care, slow stream rehabilitation and convalescent beds that could be redesigned to meet the vision and goals of the proposed model. The evidence clearly supports that transitional care can be used to enhance the system’s capacity to transition people to less intensive levels of care or back to the community, resulting in optimal system flow.

Although most MH LHIN provider agencies appear to be moving in the direction of adopting the key concepts of this new model, full adoption will require executive level commitment and dedicated change management support as the proposed model represents a significant shift in practice and philosophy from the current practice in all facilities. The following recommendations are proposed to support the adoption of the new model.

Recommendation 1: The MH LHIN adopts the proposed Transitional Care Services Framework, including the program definitions and goals, as developed by the Transitional Care Work Group.

- 1.1 Develop a budget and implementation plan to guide the redesign of existing complex continuing care, slow stream rehabilitation, Restore and LTC beds within the MH LHIN
- 1.2 Realign existing complex continuing care beds to create a 14 – 24 Regional Specialized Behaviour Unit at THC in 2009/10.

Trillium has been identified as having the capacity to immediately open 25 beds which would instantly improve patient flow at all MH LHIN hospitals by transferring patients with complex behaviour issues currently occupying acute and complex continuing care beds. This patient population has very long lengths of stay.

- 1.3 Development and siting of Regional Specialized Programs to commence in 2010/11
- 1.4 All specialized programs will be developed with the input of specialized providers from across the MH LHIN, i.e. Peel Halton ABI Service, Respiratory, West Park, Geriatric Medicine and Geriatric Psychiatry specialists.
- 1.5 The Palliative Care - core program will be developed in collaboration with the MH LHIN Palliative Care Advisory Team to ensure alignment with the proposed MH LHIN palliative care model. The team will also assist in determining the appropriate bed capacity for this service.

Recommendation 2: Designate a lead organization to assume accountability for the development and implementation of the Regional Transitional Services Program.

- 2.1 Develop an implementation accountability and authority framework
- 2.2 Create a regional steering committee to oversee implementation
- 2.3 Designate an administrative and medical lead with the accountability to refine and implement the proposed transitional service model with the MH LHIN.
- 2.4 Engage external experts are required e.g. Providence Health Care

Recommendation 3: *Develop regional standards to support the design and implementation of transitional services to ensure equitable access; with clearly defined admission and discharge criteria for all providers of transitional services (hospital and LTC based programs).*

- 3.1 The Medworxx tool will be used to assist in identifying appropriate admissions and discharges in acute care and hospital based transitional care programs (core and specialized programs)
- 3.2 Only patients who meet the eligibility criteria will be admitted to Transitional Services Programs, to ensure and support optimal patient flow.
- 3.3 Develop LHIN wide admission criteria and screening tools that clearly define the differences of transitional services from acute care services to ensure that health care providers are able to identify potential patients early in the admission process.
- 3.4 Consolidate the Convalescent Care program into the Restore program and develop regional standards which include expanded patient eligibility criteria and guidelines that support smooth, seamless and timely transitions.
- 3.5 Commission an external audit team to review all long stay patients currently occupying a complex continuing care bed against the new criteria to determine appropriateness and the identification of barriers to discharge. (Medworxx could be utilized to assist in the review.)
- 3.6 Explore the opportunity to relocate long stay complex continuing care patients who are appropriate for LTC to support care in the appropriate location. This would significantly increase the capacity within the hospital based transitional care programs.

Recommendation 4: *Develop structures and process to ensure appropriate system flow to and from all transitional services (hospital and LTC based programs).*

- 4.1 Develop processes and targets to support the smooth transition of patients between settings; acute to hospital based transitional services, acute to LTC based transitional services and hospital based to LTC based transitional services and transitional services to long term care or home.
 - *Leading practice bench marks; patients should be accepted or rejected within 24 hrs of referral to the service and admitted within 24 hours of acceptance.*
 - *Leading practice for discharge disposition from transitional service programs is 80% of patients being discharged home to the community.*
- 4.2 Ensure that discharge planning is integrated across the continuum of transitional services and that dedicated staff are available for screening referrals, determining eligibility and completion of InterRAI assessments.
- 4.3 Review current hospital charting and documentation policies and procedures to ensure efficient processes are in place to support transitions between acute care and hospital based transitional programs.
- 4.4 Identify designated staff in each site to be “Transitional Admission Coordinators” who would be accountable for case finding, determining eligibility and educate staff and physicians about the new program model.

Recommendation 5: *Develop and implement a human resource strategy to support the implementation of transitional care, including but not limited to:*

- 5.1 Education and training of all current transitional care service providers on the new model of care.
- 5.2 Education for all staff and physicians on the new model of care to support case finding.
- 5.3 Recruitment of staff with the appropriate skill mix.
- 5.4 Recruitment of staff and physicians with specialized training (geriatrics, palliative, rehabilitation, etc).
- 5.5 Ensure the physician compensation model is adequate to support the shift to a higher acuity patient.

Recommendation 6: *Develop a performance management and monitoring framework to assess the clinical and system success of the transitional programs and adjust the implementation as required to achieve maximal benefit for patients and the system.*

- 6.1 Develop regional staffing and funding models for all transitional services.
- 6.2 Develop outcome and efficiency indicators with clearly identified targets for all programs and processes.
- 6.3 Develop a process to provide reports and indicators for individual programs, i.e. palliative, complex medical, etc.

Recommendation 7: *Ensure appropriate transitional bed capacity is available to achieve the vision and goal of the proposed transitional services model.*

- 7.1 Develop a demand model that is integrated with acute care and LTC to determine the appropriate transitional bed capacity required to achieve improved patient outcomes and optimal system flow.
- 7.2 Realign and consolidate the existing complement of complex continuing care and slow stream rehab beds to support the implementation of the proposed specialized transitional service model.
- 7.3 Increase access to restore beds within all MHLHIN communities by increasing the number beds. (Consider facilities with idle beds).
- 7.4 Temporary Restore beds/units may need to be created with existing complex continuing care beds while LTC capacity is developed to support patient flow.
- 7.5 Develop and implement specialized LTC programs to support full implementation of the transitional services model.

Recommendation 8: *Develop a communication plan to educate staff, physicians and the public about the new program and the changes it will bring to the health care system.*

- 8.1 Develop a strategy to “rebrand” complex continuing care as the new “transitional care” a specialized service that will provide goal oriented short term transitional care versus long term care and permanent housing.
- 8.2 Develop a strategy to emphasis the shift in transitional care to specialized programs aimed at a higher acuity patient with complex health conditions, with the goal or discharging patients home.

Recommendation 9: The MH LHIN explores the opportunity to expand transitional care to include ambulatory and community based care in the future.

6.0 Strategy Implementation

It is recommended that the implementation of this strategy be managed within three (3) high level phases.

Phase 1 (January/10 – March 31/10)

- Realign existing complex continuing care beds to create a fourteen(14) to twenty four(24) regional Specialized Behaviour Unit at Trillium Health Care
- Confirmation of lead agency and program leadership
- Development of budget detailed implementation plan
 - Implementation Plan – funding, staffing models, program standards, outcomes, etc
 - Demand, simulation modelling to determine appropriate system capacity and targets to support optimal system flow
 - External review of long stay complex continuing care clients
 - Identify siting for additional Restore programs
- Engage LTC Providers and CCAC as key stakeholders

Phase 2 (April 2010 – March 2011)

- Execution and implementation of the plan
- Implement LTC Specialized Programs and increased Restore capacity

Phase 3 (March 2011-2012)

- Implementation of Hospital Based – Specialized Transitional Programs
- Implementation of Hospital Based – Core Programs