Transitional Care
Program Framework

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1. Context

To support the objectives of the ER/ALC Strategy and the achievement of ER Length of Stay and ALC targets, LHINs and Health Service Providers (HSP) have applied Aging at Home and Urgent Priorities Funding to increase the capacity and flow of patients across the health system by developing temporary or transitional care beds.

The creation of transitional care capacity in hospitals, long-term care homes (LTCHs) and retirement homes has resulted in a high degree of variability of initiatives in terms of eligibility criteria and patient mix.

Clarification regarding the intent, nature and parameters of this type of care is required to enable a common understanding and frame of reference so that services are developed and implemented in alignment of the ER/ALC Strategy goals and to support improved data monitoring and reporting efforts. Investments in a Transitional Care Program will require that HSPs and LHINs collect data and report outcomes that demonstrate value for money consistent with the ER/ALC Strategy. The data elements and reporting mechanism are described in Section 5 of this report.

This document serves to clarify:

- The framework within which transitional care may be established;
- The definition of a Transitional Care Program within the hospital setting; and
- The reporting requirements associated with the creation of net new beds operated under the Transitional Care Program Framework.
2. Transitional Care Program Framework

The Transitional Care Program is a program established to enhance and add bed capacity within the health care system to support the achievement of the ER/ALC Strategy objectives.

This program refers to services offered to individuals residing in net new beds created subsequent to Ministry direction in July 2008, operated in accordance with governing legislation and funded through the Aging at Home and LHIN Urgent Priorities Funding. The program, therefore, will be comprised of Convalescent Care Beds and Interim Long-Term Care Beds in the community, as well as, Transitional Care Beds in acute/post-acute hospitals. Within acute/post-acute hospitals, the definition of Transitional Care Beds will apply (see page 5).

Transitional Care Programs may exist in either the community or hospital settings and include both restorative type programs as well as additional Interim LTCH beds.

1. **Restorative:** A program which provides specialized restorative care focused on returning individuals to their highest level of independence in the community. Includes both hospital and community based programs (i.e. CCC, Rehab, or Convalescent Care – see page 6 for definitions).

2. **Interim LTCH:** Through expansion of the existing interim long-term care in accordance with Interim-Long-Term Care parameters, this program builds additional Long-Term Care Home capacity to support the flow of ALC patients designated to be discharged to Long-Term Care while maintaining their health status.

To support enhanced patient flow and recovery processes, LHINs and Health Service Providers are required to consider the development of Restorative Transitional Care Programs as a first priority to building capacity and Interim Long-Term Care only once they have maximized Restorative Transitional Care Program options.
3. Transitional Care Program in the Hospital Setting

To ensure programs established in the hospital setting align with the intended ER/ALC objectives, the following definition has been developed.

**Transitional Care Beds:** *Net new* beds, established in hospitals subsequent to July 2008, funded through the Aging at Home/LHIN Urgent Priorities Funding, targeted towards ALC patients in acute/post-acute care that provide specialized restorative care focused on returning individuals to their highest level of independence in the community.

These beds must have specific criteria for admission, a length of stay target, a clear plan of care with specific goals, and a discharge plan with home as the primary discharge site where feasible. These beds must support the achievement and maintenance of optimal levels of functioning and independence as primary outcomes that must be measured and reported.

Within the hospital setting, under the Complex Continuing Care Framework, there are two functional centres within OHRS that should be used to report Transitional Care Beds in hospital - CCC Transitional and CCC Reactivation/Restorative (see page 6 for definitions). Rehab is another possible categorization for this type of support.
### 4. Summary of Transitional Care Program Settings and Bed Types

<table>
<thead>
<tr>
<th>Community</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interim LTC</strong></td>
<td>Beds in Long-Term Care Homes or Retirement Homes that are licensed and approved by the Ministry. The beds exist for a temporary period of time under the terms of a service agreement for interim beds for individuals who are on a wait list for a Long-Term Care Home and have been discharged from a public hospital. The home must meet the legislated requirements under the Long-Term Care Homes Act. Criteria for eligibility apply with CCAC as gatekeepers to the Interim Bed Program.</td>
</tr>
<tr>
<td><strong>Convalescent Care</strong></td>
<td>Beds in Long-Term Care Homes or Retirement Homes that are licensed and approved by the Ministry. The home must meet the legislated requirements under the Long-Term Care Homes Act. These beds are provided to an individual who requires a period of time in which to recover strength, endurance or functioning and who are likely to benefit from a short-stay (up to 90 days) in a Long-Term Care Home before returning home. The Convalescent Care Program expands the range of options for individuals who do not need acute care but cannot yet manage at home; these individuals may be coming directly from hospital or may be living in the community. CCACs are the gatekeepers to the Convalescent Care Program.</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
</tr>
<tr>
<td><strong>CCC - Transitional</strong></td>
<td>A nursing unit where the beds are designated for the provision of care for patients who no longer require acute/rehabilitation hospital inpatient services but still have medical issues and are not yet ready for discharge home and/or who are awaiting supportive placement.</td>
</tr>
<tr>
<td><strong>CCC - Reactivation/ Restoration</strong></td>
<td>A nursing care unit where the beds are designated for the provision of care for patients who have experienced a recent decline in their independent functions due to progressive debilitation and/or physical de-conditioning; who require a short period of enhanced care but have a discharge goal of home or Long-Term Care Home.</td>
</tr>
<tr>
<td><strong>Rehab (various functional centres)</strong></td>
<td>A nursing care unit where the beds are designated for the provision of rehabilitation services for inpatients that require physiological and psychosocial support related to medical and surgical conditions.</td>
</tr>
</tbody>
</table>
5. **Reporting System Requirements**

In the fall of 2009, an Expert Advisory Committee was established to develop the Transitional Care Program Framework and overarching program goals.

The identified overarching goals aim to optimize the value of TCP investments by:

- Improving patient flow and system efficiency;
- Enhancing patient care by providing restorative care to maximize the patient’s level of function and independence while in transition to their final destination; and
- Increasing the proportion of patients who return home post-discharge (vs. long-term care).

A system to collect and analyze data has been developed to monitor and evaluate the achievement of these three goals, focusing on the following key measures:

- **Readmissions** – to monitor the impact of TCPs on the frequency of unplanned ER visits and hospital admissions.
- **Patient final destination post-discharge** – to assess the proportion of TCP clients discharged to home versus to long-term care.*
- **Impact on system capacity** – to assess the impact of TCPs on % ALC Days.
- **Impact on system efficiency** – to assess the impact of TCPs on 90th percentile number of days from ALC designation to discharge.

The implementation of a TCP reporting system will facilitate the standardization of province-wide tracking and evaluation.

HSPs are required to begin collecting data, using pre-formatted Excel worksheets, for all new admissions to beds operated under the TCP Framework effective September 1st, 2010. System Measures will be reported to the LHIN and MOHLTC on a quarterly basis.

*Interim Long-Term Care clients are excluded from this calculation.
Reporting measures include the following:

<table>
<thead>
<tr>
<th>Client Level Measures</th>
<th>System Level Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Identifier</td>
<td>Average Length of Stay</td>
</tr>
<tr>
<td>Program Type (i.e. CCC, Rehab, CC and Interim LTC)</td>
<td>90th Percentile Length of Stay</td>
</tr>
<tr>
<td>Referral Source Type (i.e. Hospital, Long-Term Care Home, Retirement Home)</td>
<td>Median Length of Stay</td>
</tr>
<tr>
<td>Referral Source Name and Master Number (i.e. XXX Village Nursing Home - 3619)</td>
<td>% Admitted to TCP from Acute Care</td>
</tr>
<tr>
<td>TCP Admission Date</td>
<td>Total # Admitted to TCP per Quarter</td>
</tr>
<tr>
<td>TCP Discharge Date</td>
<td>Total # Discharged from TCP per Quarter</td>
</tr>
<tr>
<td>Discharge Destination (Post-TCP)</td>
<td>% Clients Exceeding 60 days Length of Stay</td>
</tr>
<tr>
<td>Return to ED While Admitted to TCP</td>
<td>% Clients Exceeding 90 days Length of Stay</td>
</tr>
<tr>
<td>Other Discharge Destination – Explanation</td>
<td>% Clients Discharged Home*</td>
</tr>
<tr>
<td></td>
<td>% Returned to ED While Admitted to TCP</td>
</tr>
</tbody>
</table>

*Interim Long-Term Care clients are excluded from this calculation.

**Reporting Process:**

HSPs will enter client level data using the *Client Level Measures Worksheet* provided by the LHINs. System level measures will automatically be calculated in the *System Level Measures Worksheet*. HSPs will validate and send system level measures to their LHIN on a quarterly basis. LHINs will not receive client level data. LHINs may amalgamate the Ministry’s reporting template with existing templates as long as the formulas are maintained.

Key measures will be included in the performance management report (referred to as Stocktake) and discussed by the LHINs and Assistant Deputy Minister on a quarterly basis. Additionally, the LHINs are required to provide an updated inventory of TCP beds, and a summary of all TCP bed creations/closures and conversions, on a quarterly basis.

As a next step, the Ministry has begun investigating the collection of post-discharge data (e.g. re-admission rates and return visits to the Emergency Department). System Measures and post-discharge data (when available) will be reviewed by the LHIN and submitted to the Ministry for further analysis on an on-going basis.
All HSPs must continue reporting to the Canadian Institute for Health Information (CIHI) using the Complex Continuing Care Reporting System (CCRS) and/or the National Rehabilitation System (NRS). Despite the 3-6 month reporting lag, data from these reporting systems can be used to validate TCP performance management metrics and may eventually be used to track the Resident Assessment Instrument (RAI) and Functional Independence Measure (FIM) scores of TCP clients.