# 2019/20 Tip Sheet for the Short-Term Transitional Care Models (STTCM) (October 15, 2019)

**REINTEGRATION CARE UNITS (RCUs) & CAREGIVER RECHARGE SERVICES (CRS)**

This “Tip Sheet” has been developed as a ***reference tool*** to support hospitals in transitioning patients to the Short-Term Transitional Care Models (STTCM) that continue to be pilot-tested in the Toronto Central LHIN. Referrals to all of the STTCM providers (see below) are sent to and being supported by a Centralized Referral Management (CRM) Team that are responsible for:

1. Ensuring the referral is complete. *(Note: This will include confirmation of the discharge destination for patients post-RCU and assessment of whether the discharge plan is realistic and achievable within the expected length of stay for the RCU at the time of referral.)*
2. Maintaining flow in the RCUs through timely matching and feedback to hospital partners (usually within one to three business hours) regarding the status of referrals (e.g., more information needed, patient matched or ineligible). Matching is based on a number of factors including: patient’s care needs (PSW and nursing), patient’s confirmed discharge plan and patient’s goals for RCU stay as well as immediate vacancy.
3. Facilitating timely communication of vacancies to hospital partners and surge needs to RCU providers during flu/surge season (November- March) to a maintain effective system flow.
4. Providing telephone and e-mail consultations to hospital partners in regards to potential patients they would like to refer to an RCU/Caregiver Recharge Service and providing further navigation and information, as needed, prior to referral of patient to the RCU.

**2019/20 Short-Term Transitional Care Model (STTCM) Providers in the Toronto Central LHIN**

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| HSP | Program | Capacity | Unit |
| Bellwoods | RCU | 15 | Units |
| Bellwoods | CRS (In-Home PSW Respite) | 12, 700 | Visits/Hours |
| Hillcrest Reactivation Centre | RCU | 75 | Beds |
| Les Centres d”Accueil Heritage(\*\* Francophone patients only) | RCU | 2\*\* | Beds |
| LOFT Community Services (Pine Villa) | RCU | 34 | Beds |
| LOFT Community Services (WSW) | RCU | 12 | Beds |
| Reconnect Community Health Services | RCU | 17 (13 beds confirmed; 4 beds – tbc) | Beds |
| Rekai Centres | RCU | 10 | Beds |
| SPRINT Senior Care (Pine Villa) | RCU | 34 | Beds |
| St. Clair O’Connor Community | CRS (Adult Day Program) | 10 | Weekly Spaces |
| ST. HILDA’S | RCU | 9 | Beds |
| The Neighbourhood Group | RCU | 10 | Units |

**What are Short-Term Transitional Care Models?**

The Toronto Central LHIN, in partnership with the Ministry of Health and Long-Term Care (MOHLTC), is continuing to invest in Short-Term Transitional Care Models (STTCMs) designed to meet the transition needs of patients in hospital who have been designated alternate level of care (ALC) and/or at risk of ALC. **Models being tested include Reintegration Care Units (RCUs) and Caregiver ReCharge Services (CRS).**

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| STTCMs | Description |
| Reintegration Care Units (RCUs) | These units are designed to support patients designated or at risk of ALC waiting to return a community setting. The RCUs provide patients with a safe and supportive place to go following their discharge from hospital to allow additional time to:* Increase their strength, mobility, and endurance
* Improve their ability to manage their activities of daily living at home or prepare them to manage in another community setting
* Enhance patient’s confidence in their ability to meet their health and safety needs within a community-based setting
* Connect patients with new community services or reinitiate existing services to meet their needs.
* Develop a sustainable transition plan for patients to return to the community or transition to a more appropriate environment to meet their needs.

**All RCUs have a maximum length of stay** that differs depending on the program; however, actual length of stay may be shorter and is based on individual patient goals. Patients are not matched to programs on length of stay alone but on needs of the patient, goal of care and vacancy first and then how length of stay may impact/interact with these. For all sites, patients must have a clear post-RCU transition plan. |
| Caregiver ReCharge Services (CRS) | CRS programs support caregivers of patients designated or at risk of ALC through the provision of in-home Personal Support Worker (PSW) respite services and/or supervised programming in a group setting (i.e., Adult Day Program). These services are only available during day time hours and are intended to provide relief for the caregiver only (not supplement services for the patient or replace other community supports or services). Once assessed as eligible, caregivers receive time-limited support, with maximum support levels established within each program.  |

**What are the roles of the STTCM partners during surge & flu season?**

To ensure a proactive response to hospitals experiencing surge or high occupancies, the following clarification of roles has been confirmed.

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| Role of the Toronto Central LHIN  | * *Notice of Priority Surge* to be sent to Centralized Referral Management Team (CRM) from Toronto Central LHIN. This will validate that the hospital is in surge and will identify hospitals with the "highest priority" during times when multiple hospitals are impacted by surge.
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| Role Centralized Referral Management (CRM) Team  | * To prioritize referrals from surge sites each day between the hours of 8:30 a.m. and 4:30 p.m. Monday to Friday.
* To provide updates to the Toronto Central LHIN, as needed.
* To distribute regular weekly bulletins reporting on referral trends, occupancy, service navigation related to RCUs/CRSs.
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| Role of STTCM HSP Partners  | * To provide immediate reporting of vacancies (or anticipated vacancies) to CRM Team to help facilitate quick turnaround of matching to available beds.
* To participate in Hospital ALC or GIM rounds (as per existing partnerships) to raise the profile of all STTCM partners and their services, and to facilitate and support hospitals in identifying and making appropriate referrals through CRM. *(Note: Same day processing /admission will be accommodated whenever possible at Hillcrest only, if all necessary information is received before 1:00 p.m., and if eligibility criteria has been met and a bed is available.)* All other HSP partners are working to complete intake as quickly as possible and will work with CRM to prioritize referrals from surge sites to facilitate the quickest admissions.
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| Role of Hospitals | * To continue proactive management and transition planning for ALC patients or those at risk of becoming ALC.
* To set early expectations with families, patients and caregivers regarding transition back to home following discharge. (*Note: If patient requires additional time outside of an hospital setting, discuss STTCM’s programs as a facilitator to support return home or to the community.)*
* To obtain consent and ensure the referral application is complete and sent to CRM in a timely way to expedite transitions.
* To review the CRM weekly bulleting and consult in a timely way with CRM Team if questions arise to facilitate matching to the most appropriate program.
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**Who is eligible for referral to a STTCM?**

Admission of patients to a RCU will be guided by the following criteria:

1. Patient has a valid OHIP number.
2. Patient is medically stable (Note: there are no physicians regularly on-site at RCUs).
3. Patient has a confirmed transition location and discharge plan that can be met within the maximum length of stay.
4. Patient requires nursing and/or personal care beyond what can be provided at home by Home & Community Care for a short period of time.

*See Appendix 1 for examples of types of actual patients who have been successfully transitioned to a Reintegration Care Unit (RCU) and/or have received Caregiver ReCharge Services (CRS). This list is being provided to hospitals to help identify appropriate patients for referral through CRM.*

**Who is not an appropriate candidate for referral to a STTCM?**

1. Patient has no PSW or nursing needs, with no other goals other than for temporary housing.
2. Patient is unable to use a call bell independently to obtain needed support.
3. Patient requires close physician monitoring (i.e., for pain or complex symptom management or regular medication adjustments/changes in care based on presentation).
4. Patient requires hands-on assistance with feeding and/or they are at high risk for aspiration.
5. Patient requires supervision or support from someone at their bedside 24/7 due to their unpredictable behaviour placing them at high risk for falls and/or staff injury (e.g. a patient who consistently attempts to get up independently from bed and/or a chair despite their inability to transfer independently).
6. Patient has unmanaged /poorly controlled behaviours.

*Note: There is limited capacity to support patients who are “bed-bound” or require full feeding support. These patients will be considered on a case-by-case basis. The CRM Team is pleased to provide hospital providers with consultation and advice on these and other plans for patients with complex needs/unique goals or where it is not clear if STTCM programs are the right resource,*

**Referral Process for all RCUs and CRS Programs**

1. **Complete the full** **referral form.** The latest version is available at <http://bellwoodscentres.org/> under Programs & Services, Centralized Referral Management.
2. **Email or fax (**as per the instructions on Page 1 of the form) **the completed referral form to Centralized Referral Management**. The CRM team will **review** and **match** your patient to a RCU. If all the information is complete and meets the program criteria, you will receive a confirmation by email of who the provider is and the “next steps” required to facilitate admission to the RCU. If information is missing our challenges in matching are noted, the CRM Team will reach out via email/telephone to clarify/update/explore etc. until a match can be made or all options exhausted. You will usually be notified within one to three business hours.
3. **If the patient is matched, the RCU Team will work with you to plan the quickest transition possible**. Ensuring a safe, timely and effective transition is the CRM and RCUs priority; therefore, the RCU will contact you to make arrangements to move the patient to the RCU as quickly as is feasible.

**APPENDIX 1: EXAMPLES OF PATIENTS WHO HAVE BEEN SUCCESSFULLY TRANSITIONED**

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| PATIENT COHORTS | DESCRIPTION OF PATIENTS ADMITTED TO STTCM  |
| ACUTE CARE HOSPITALSPOST-ACUTE HOSPITALS (Rehabilitation and Complex Continuing Care)EMERGENCY DEPARTMENTS | * Patient who needs to achieve weight bearing status before returning to rehab bed
* Patient with mobility issues (at risk of increased falls) who would benefit from time to increase strength and practice in mobilizing in a supervised environment
* Patient waiting for home modifications to be completed
* Patient requires more time for family to arrange services and supports at home
* Patient with significant changes in function (stroke, amputees, spinal cord injury) who would benefit from time participating in self-care in a structured/supportive environment with time to practice skills before transitioning home
* Patient requires assistance/support learning new ADLs (e.g., stoma, G-tube and catheter care)
* Patient completing active outpatient treatment (e.g., chemo/radiation) and requires supportive environment due to side effects (e.g., mobility, exhaustion, cognition, IADL and ADL support) to optimize recovery
* Patient requires IV therapy (time-limited) and is not a candidate for receiving nursing supports through Home and Community Care.
* Patients who can no longer live alone or their caregiver can no longer meet their needs and have a strong post-RCU plan (i.e., new address with supports available, demonstrated participation from patient/ caregiver in the planning process).
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| SOCIAL / HOUSING NEEDS *\*Please note, if patient is moving to a new housing arrangement post-RCU, there should have already been some exploration by hospital team of options and finances as social work support and/or discharge planning is NOT routinely available in the RCU setting. \** | * Patient apartment/unit is under accessible renovations.
* Patient with a history of hoarding admitted to the RCU while arrangements being made to clean the home, while arranging additional supports/services required for a sustainable transition.
* Patient deciding not to return home to an abusive relationship requiring assistance with some ADLs while securing housing.
* Patient requires alternative housing during a period of recovery such as a homeless patient requiring a safe environment to support recovery from cardiac surgery or fracture.
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| CAREGIVER NEEDS | * Patients whose barrier to discharge is caregiver burnout and RCU able to provide short-term relief with a plan to return home.
* Palliative patient where caregiver requires short period of respite.
* Caregiver unable to care for the patient due to their own acute health event.
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| BEHAVIOURAL NEEDS | * Patients with responsive behaviours related to dementia, mental illness, substance use and other neurological conditions who do not require 1:1, PRN medication to minimize imminent risk to self or others on a frequent basis.
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