The Role of the Transition Planner at a Reactivation Care Centre (RCC)

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St. Joseph's Health Centre Reactivation Care Centre Church site

PURPOSE

The development of the Transition Planner (TP) role arose from an identified need for an individual with expertise of the health system to facilitate and expedite discharge back to the community.

RELEVANCE

The role of the TP has implications at the organizational and health systems level including decrease the average length of stay, and reduce the ALC rates. The work of the TP is critical to the process of successfully moving patients out of acute care settings to destinations suited for medically stable clientele. .

STUDY SAMPLE AND INITIATIVE

The RCC is a 30 bed unit using an innovative service delivery mode to provide specialized programming not typically available to ALC patients in acute care. The mandate of the RCC is, through activation, to restore social, cognitive, and physical function to facilitate transition back to the community with increased supports. The Barthal index was measured on patient admission and discharge, and compared over time. In addition, we collected descriptive data on the location of discharge for all included patients and average length of stay.

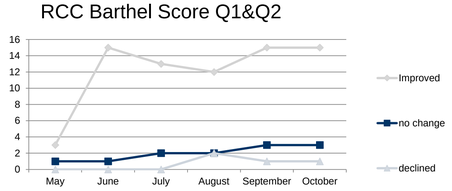

Figure 1: Total number of Barthel Scores per month showing improvement, no change or declined

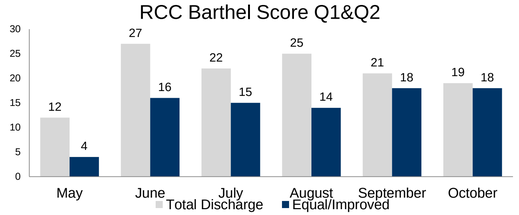

Figure 2: Total number of discharges per month with the number of Barthel scores with improvement per month.

FINDINGS

Figure 2 displays the total number of discharges per month for the RCC as compared to the number of patients who have had an improvement in their function as reflected in the Barthel index. The TP thus uses the Barthel score as a measure to discharge a patient from the facility and successfully return to the community with supports. In September, there were 21 discharges from the RCC total. From those 21 discharges, 18 showed an improvement in their Barthel score. In October, 19 patients were discharged and 18 patients displayed an improvement in their Barthel score.

Figure 3 shows the total number of discharges per location and month. The percentage of discharges home in June was 38%, in July was 41%, in August was 44% and in September and October were 52% and 58% respectively. Home is defined as a community dwelling including, but no limited to: personal home or apartment, subsidized housing and a retirement home.

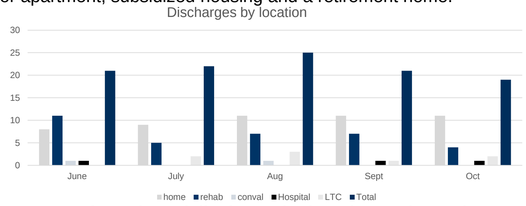

Figure 3: Total number of discharge by location and month

ALC Discharge Destination	No. Cases	Avg. Total LOS (days)
Convalescent Care Bed	3	33.67
Home-with LHIN services	33	24.03
Home with community Services	5	15.40
LTC	6	74.67
No Match	13	17.46
Rehab Bed-Geriatric	3	12.0
Rehabilitation bed-LTLD	20	28.35
Rehab Bed-MSK	2	15,0
Rehab Bed-other	6	22.67
Supervised or assisted living-Retirement home	7	36.29
Supervised or assisted living-supportive housing	1	83.00
Grand Total	99	27.80

Figure 4: Discharge destinations and Length of Stay (LOS) YTD. Data source: WTIS

Patients at the RCC were able to maintain or restore optimal functional capacity. Figure 4 displays the average length of stay (LOS) for patients by discharge destination. The patients were discharged from the RCC with an average LOS of 27,8 days. Thus patients were reactivated sufficiently for safe discharge back to the community with LHIN supports and thereby assisting with patient flow at the hospital. A Total of 99 patients were discharged to the community and a variety of settings within the community.

DISCUSSIONS

The RCC model allows patients to reactivate sufficiently enabling their return to home with supports. The patients have improved their Barthel Index scores to sufficiently improve their function to return to the community. The role of the TP is imperative to this model to ensure that patients receive the appropriate supports, encouraging successful discharge from the hospital and allowing those who would otherwise remain in acute care to reactive to return home, improving patient flow.

CONCLUSIONS

Patients at the RCC were able to maintain or restore optimal functional capacity. This allows for an improved quality of life for the patients to achieve their goals. The role of TP is essential to providing supports in the community for the patients and families to facilitate a safe and successful discharge. Patients from the RCC stay for an average of 27.8 days and are successfully discharge out of the hospital to assist in reducing ALC rates.

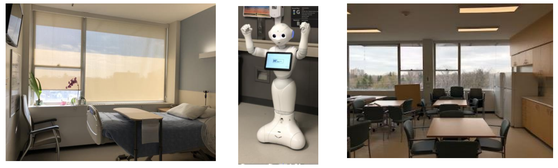

Figure 5: A patient room at RCC, the robot therapy, the patient dining hall.

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