Ontario Health

Operational Direction
Rehabilitation and Complex Continuing Care
Capacity and Flow

ISSUED TO:	Acute Care and Rehabilitation/Complex Continuing Care Hospital CEOs
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Ensuring patients across Ontario receive the right care in the right place at the right time is a key priority for our health system. Thank you to you and your teams for the work you do every day in support of this goal.

Currently in Ontario, there are more than 4,500 patients designated as requiring an alternate level of care (ALC) in acute care and rehabilitation/complex continuing care (CCC) hospitals, with approximately 25% of patients in acute care waiting for rehabilitation and CCC. As we look ahead to the fall/winter and the accompanying resurgence of respiratory viruses, we anticipate capacity pressures across the health system. Given this context, it is increasingly important to optimize rehabilitation and CCC capacity to support ALC reduction efforts and improve patient access to care.

Acknowledging implementation of the Operational Guidance may be nuanced depending on geography and in rural and remote locations, Ontario Health remains committed to working with system partners to improve access, occupancy, throughput, and flow in all sectors across the province. A province-wide target of reducing ALC volumes by 10% per year over the next 3 years has been set to help concentrate our collective efforts to improve access to care.

To support target achievement, improved utilization, patient flow, and overall system capacity, Ontario Health is issuing the following direction and guidance (below) to hospitals and health service providers that operate rehabilitation and CCC beds as a free-standing facility or integrated within an acute care facility:

1. All rehab and CCC hospitals will work towards a target occupancy rate of >95%
2. All hospitals will work towards achieving ALC throughput targets of >1
3. All hospitals will work to implement the actions and approaches outlined in the attached Operational Guidance that apply to them, recognizing rural and northern constraints
4. All hospitals will work with their Ontario Health region on the above noted improvement efforts

Your Ontario Health regional team will continue to work closely with you on local capacity, access and flow efforts and will follow up with organizations shortly to support implementation efforts over the summer.

Thank you for all that you are doing to provide care for the people of Ontario.

Operational Guidance

Provincial Target: All CCC hospitals/facilities/bedded programs will work towards a target occupancy rate of >95%

For acute care hospitals:

1. Implement processes to work towards 7 day/week discharges to rehab and CCC.
2. Ensure a proper discharge plan is established and communicated to rehab and CCC hospitals/bedded programs and other discharge destinations including:
    - A transfer of accountability process,
    - A comprehensive discharge summary, including the latest medication information, as outlined in the GTA Rehab Network Discharge Checklist, and
    - Physician-to-physician phone calls using a standardized tool such as IPASS (as required).

For rehab and CCC hospitals/facilities/bedded programs:

3. Develop a plan to implement 7 day/week rehab and CCC admissions, with consideration for:
    - Medical coverage,
    - Clinical support staff (i.e., pharmacy, admitting),
    - Rehabilitation therapy staff, and
    - Access to environmental services to facilitate room cleaning and bed turn around.
4. Develop a plan to establish expanded hours of rehab and CCC admission which may include implementation of after-hour medical coverage, expanded therapy and clinical support coverage, including pharmacy.
5. Stagger discharges throughout the week to facilitate continuous acute care flow and avoid fluctuations in occupancy.
6. Create flex beds to accommodate any late or failed complex or rehabilitation discharges to ensure same-day acute care admissions are not cancelled. Ideally, admissions including transportation should be pre-booked where possible.
7. Ensure bed holding policies align with the Guidance to support the Repatriation of Patients to Bedded Levels of Rehabilitative Care in Freestanding Rehab/Complex Continuing Care Hospitals.
8. Develop proactive surge strategies for rehab and CCC occupancy to support capacity pressures across hospitals, particularly during respiratory viral season and other increases in acute care demand.
9. Adopt flexible admission criteria to accommodate patients on the wait list for rehab and CCC and respond to changing demand (i.e., summer surgical ramp downs, low occupancy periods for speciality programs). Consider off-service admissions and mixed units for non-specialized programs to enable opportunities to flex resources between different bed types (*see*: Rehab Care Alliance Bedded Levels of Rehab).
10. Ensure COVID-19 infection prevention and control (IPAC) measures (i.e., admission testing, isolation requirements and duration, management of aerosol-generating medical procedures) are adapting to the current phase of the pandemic and community viral transmission rates. Recommendations based on best practices and the current phase of the pandemic include the following:
    - All patients should be screened upon admission and actively monitored while in hospital for COVID-19 and respiratory virus-compatible symptoms.

- Routine COVID-19 testing of asymptomatic patients is no longer required on admission.
- Routine isolation of asymptomatic patients on admission is no longer recommended.
- All patients with suspected or confirmed COVID-19 or respiratory illness should be placed on Droplet and Contact Plus precautions (personal protective equipment [PPE] includes fit-tested N95 respirator, eye protection, gloves, and gown) until reassessed by the IPAC team at the earliest possible opportunity to determine testing requirements and duration of isolation. Note: access to timely diagnostic testing will facilitate the determination of a plan of care and the requirement for ongoing isolation.
- All staff must use Airborne/Droplet Contact precautions and PPE (N95 respirator, face shield, gown, gloves) when performing aerosol-generating medical procedures on patients with suspected or confirmed respiratory virus infection. Note: Asymptomatic patients with a tracheostomy, chronic continuous positive airway pressure (CPAP) or on high-flow oxygen/mechanical ventilation will no longer require negative pressure rooms and airborne/droplet/contact precautions.
- In general, movement of patients to and from an outbreak unit is not recommended; however, given the importance of access to rehab/CCC for system flow and patient needs, transfers may be considered after a discussion between IPAC programs and agreement from public health. The accepting facility should admit the patient preferably into a private room, if this is possible, and maintain Additional Precautions as required.

Provincial Target: All hospitals will work towards achieving ALC throughput targets of >1

For all hospitals:

11. Implement the ALC Leading Practices and the Rehab Care Alliance and Provincial Geriatrics Leadership Ontario Framework for Older Adults Living with Frailty: Older Adults with Frailty Rehab Guidelines to prevent delays in transitions of care and improve the quality of care, including patient and caregiver engagement in care/discharge planning, access to specialized supports, and transitions from hospital to the next level of care.
12. Ensure a plan of care is developed by all members of the care team with the patient and relevant community partners to address care needs with a focus on transition to the pre-admission destination where possible.
13. Ensure frequent re-assessment of patient status, an essential part of the care process so that changes and resulting support needs are identified as early as possible, and the care plan and goals of care are adjusted accordingly.
14. Ensure there is a scheduled opportunity for the interdisciplinary team to review patients identified as "at-risk" (e.g., "at-risk" ALC rounds) at least weekly. "At-risk" ALC rounds include a representative at a director/vice-president-level, internal stakeholders, key external agencies, and discussion around a review of risks for each patient to optimize discharge options, develop creative discharge solutions, and provide appropriate transitional supports, including augmentation of community supports to facilitate timely discharge.
15. An "at-risk" resolution table is developed, where challenging barriers to transition, including the need for specialized equipment and behavioural supports, can be discussed, and addressed.
16. Develop strategies to support patient transfer back to rehab and CCC from the ED as quickly as possible with added supports as required.
17. Develop a workforce sustainability strategy that includes key concepts such as staff wellness/resilience, recruitment, and retention to ensure we have appropriate staff to meet patient needs.

18. Build partnerships between acute care and rehab and CCC hospitals/bedded programs where necessary to educate rehab and CCC staff to meet the rehabilitative care needs of patients (i.e., dialysis training for nurses so patients can be admitted and still receive home hemodialysis and peritoneal dialysis treatment; administration of specialty medication and treatment such as parenteral nutrition).

For acute care hospitals:

19. Ensure ALC patients are accurately designated, not only based on medical stability in acute care, but also based on restorative potential[1] and completion of investigations and/or treatments that can only be offered in acute care.
20. Align referral processes with the Provincial Referral Standards Reference Guide. Note that patients do not need to be designated ALC for a referral to take place.
21. Develop and implement forecasting processes within team rounds, leveraging length of stay best practices for targeted populations, to provide a best estimate of when admitted patients will be ready to transfer to the next level of care.
22. Consider opportunities in the ED to support avoidance of acute care admissions or reduce functional decline of patients who are no-bed admits (i.e., GEM, rehab staffing), in alignment with senior friendly care principles.
23. Enable review of newly designated ALC patients by rehab and CCC admissions coordinators to seek out appropriate referrals.

For rehab and CCC hospitals/facilities/bedded programs:

24. Develop a plan to maintain daily rehabilitation care by allied health team members while also expanding to a minimum of 6 days/week, and ideally 7 days/week, to decrease length of stay and improve flow.
25. Follow best practices in rehabilitative care as outlined in best practice documents for key populations including: Hip Fracture, Older Adults with Frailty, Total Joint Replacements, Stroke Rehab.
26. Implement group programs and optimize models of care where all team members are working to maximize rehabilitation therapy to mitigate impact of health human resources shortages. Be creative in the staffing model and consider how to use other disciplines (i.e., therapy assistants, social services workers, kinesiologists, dietician assistant).
27. Work with acute care to develop “pull strategies” to maintain flow, especially during surge periods. Include patient flow coordinators onsite at referring facilities where possible, otherwise ensure regular contact with referring facilities to identify potential patients.

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[1] Restorative Potential means that there is reason to believe (based on clinical assessment and expertise and evidence in the literature where available) that the patient's/client’s condition is likely to undergo functional improvement and benefit from rehabilitative care. The degree of restorative potential and benefit from rehabilitative care should take into consideration the patient’s/client’s:

1. Baseline level of functioning
2. Medical diagnosis/prognosis and co-morbidities (i.e., is there a maximum level of functioning that can be expected owing to the medical diagnosis /prognosis?)
3. Ability to participate in and benefit from rehabilitative care within the context of the patient’s/client’s specific functional goals and direction of care needs.

NB: Determination of whether a patient/client has restorative potential includes consideration of all three of the above factors. Cognitive impairment, depression, delirium, or discharge destination should not be used in isolation to influence a determination of restorative potential.

28. Work with acute care to implement guidelines for direct admission to rehab and CCC from the community or emergency department. Consider referral pathways and steps outlined in the RCA Direct Access Priority Process document.

Enablers to support this guidance

- In collaboration with system partners, revisit admission criteria, programs, services, and staff skill sets at least annually to ensure they are responsive to changing demand and can address gaps in services.
- Ensure established best practice rehab care for key populations (i.e., stroke, older adults, orthopedics) is initiated in acute care.
- Review medical model to ensure alignment in terms of physician hours, presence on unit, admissions and throughput priorities, speed to action particularly on high admission and discharging units. Review on call stipends or billing guidelines to support admissions on weekends.
- Explore centralized referral and triage for rehab and CCC to create one point of access to these programs from acute care.
- Explore options to adopt eReferral processes to support flow and develop a performance scorecard to monitor key access and flow metrics at your hospital.
- Plan proactively for appropriate transportation to reduce potential admission delays.
- Partner with organizations to ensure access to Indigenous Healing Practices and culturally safe care.