Coordinated Bed Access Guiding Principles & Policies

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Table of Contents

Background 4

Governance 5

Documents & Forms 5

Roles and Responsibilities 5

Application & Acceptance to Waitlist 6

Patient Consent 8

Re-Assessment Protocol for Sending Sites 8

Bed Match, Medical Stability and Bed Offer 8

Program Transfer 9

Bed Holding 10

Waterloo Wellington Repatriation Guidelines for Post-Acute Populations 11

Bibliography 13

Appendix A Patient Transitions Steering Committee Membership Error! Bookmark not defined.

Background

In 2011, Local Health Integration Networks, Community Care Access CEO's, together with the Ministry of Health, committed to expand the role of CCACs, positioning CCACs with a greater role in connecting people to: Adult Day Programs, Complex Continuing Care, Rehabilitation and Supportive Housing. Coordinated Bed Access (CBA) was developed from this mandate, with the vision of providing centralized and equitable access to post-acute bedded levels of care in Waterloo Wellington. CBA is located with Home & Community Care Support Services Waterloo Wellington.

CBA is the single point of access to the following post-acute bedded levels of care:

Level of Care	Site Location
General Rehabilitation	Grand River Hospital - Freeport Campus St. Joseph's Health Centre Guelph Cambridge Memorial Hospital
Stroke Rehabilitation	Grand River Hospital - Freeport Campus St. Joseph's Health Centre Guelph Cambridge Memorial Hospital
Low Intensity Rehabilitation	Grand River Hospital - Freeport Campus St. Joseph's Health Centre Guelph
Activation/Restoration	Recommend that sites apply to Transitional Care
Medically Complex – Short and Long Duration	Grand River Hospital - Freeport Campus St. Joseph's Health Centre Guelph Groves Memorial Hospital
Medically Complex - Ventilator Dependent Beds	Grand River Hospital - Freeport Campus
Complex Care Palliative - Pain & Symptom Management and End of Life	Grand River Hospital - Freeport Campus St. Joseph's Health Centre Guelph
Hospice - End of Life	Hospice Wellington Lisaard House Innisfree Hospice of Waterloo region

CBA is the single point of access for patients both within the Waterloo Wellington Region and Out of Region who are in need of these bedded levels of care. Accepted standard program criteria, referral tools and process, and discharge planning approach consistent with the Home First philosophy (Waterloo Wellington LHIN Home First Steering Committee, 2013) are applied.

Governance

CBA is accountable to all Partner Organizations through the Chief Nursing Executives and Patient Transitions Steering Committee (Appendix B). Patient Transitions Steering Committee, through a committed shared vision of patient transitions, serves to ensure the sustainability of the *Home First Philosophy* as a collaborative approach to discharge planning. It serves as the vehicle to advocate and disseminate information in order to support discharge home as the ultimate goal. To facilitate home discharges, alternative destinations may be necessary to improve patient level of functional independence through the use of a rehabilitative care approach (Waterloo Wellington LHIN Home First Steering Committee, 2013).

Documents & Forms

This Guiding Principles and Policy document, and all associated documents and forms are posted to the Home & Community Care Support Services Waterloo Wellington Website: http://healthcareathome.ca/ww/en/Partners/coordinate-bed-access.

Roles and Responsibilities

CBA is responsible for:

- Receiving applications for all programs.
- Sending applications to program sites.
- Maintaining record of applications, wait list date and admission to program.

The Sending Site (i.e., Acute Care, Community or Out of Region) is responsible for:

- Assessing patient eligibility post-acute bedded level of care using established program criteria.
- Completing the application to the appropriate program.
- Communicating with the receiving sites to resolve patient specific needs. This communication is encouraged to occur in advance of application submission.
- Compliance with the appropriate program service matrix and program criteria.
- Ensuring patient eligibility and program readiness for the duration of the waitlist period.
- Providing timely patient status updates if there is change in medical status, eligibility or program readiness.
- Providing Medical Stability confirmation within the agreed upon timeline.
- Providing timely and accurate patient status updates.
- Participating and contributing in site to site conversation to resolve application concern(s).

The Receiving site is responsible for:

- Reviewing applications for program appropriateness.
- Communicating with the sending site to resolve patient specific application concerns.
- Maintaining waitlist for identified program.
- Requesting medical stability from the sending site.
- Matching patient to bed, informing the sending site and CBA of acceptance and bed offer.
- Participating and contributing in site to site conversation to resolve application concern(s).

Application & Acceptance to Waitlist

To support timely and equitable access to post-acute care, and patient flow application is to a level of care rather a specific site or location. Application to a post-acute program is made using the standard application form and program criteria, which are aligned with the Provincial Definition Framework for Bedded Levels of Rehabilitative Care (Rehabilitative Care Alliance, 2014).

Applications are shared with receiving sites when received. Receiving sites confirm patient acceptance to the wait list, and offer admission based on wait list date. Effort is made to keep patients close to home wherever possible. Applications for Specialized Rehabilitative Care Programs (i.e., Stroke, Chronic Ventilator Unit) are processed based

on clinical care pathways. Applications to Palliative Care Programs are processed based on wait list date and prioritized based on the palliative prioritization framework.

For Palliative beds, patients will be matched to their choice of site(s). The sending site will rank the patient site choice(s) at time of application. The Prioritization Framework for Palliative Bed Offer will be used to guide decision making.

Specialized Rehabilitative Care Programs

Chronic Assisted Ventilator Beds

Chronic Assisted Ventilator Complex Medical beds are located at Freeport only. The Program will review the application as soon as possible upon receipt and directly communicate with the sending site acceptance or decline of the applications.

Stroke Rehabilitation

An application for stroke rehabilitation should be submitted as soon as possible once deemed that patient will require in-patient rehabilitation. Sending sites will establish a "rehab ready date", which receiving sites will use to plan patient admission. The goal is to admit stroke patients to rehab as soon as possible in alignment with "rehab ready date".

Site Specific Applications

An application may be submitted to specific site(s) in limited situations:

- Patient clinical need can only be met at a particular site(s) as per the service matrix for that level of care.
- Exceptional patient situations that warrant a compassionate response.

All partner organizations have agreed that transportation for the ease of access by a caregiver is alone not a reason for single site exception. This policy supports the principle of first available bed.

The review and approval of a site exception is made by the sending site. By approving a site exception, the sending site accepts responsibility for impact to patient flow at their site. Each sending site will have an identified manager with responsibility for review and approval of site exceptions. Rationale and supporting documentation for site specific applications will accompany the application.

Patient Consent

Informed consent is required for patient application, and for release of information to the post-acute site(s). Expressed consent is obtained using the Letter of Understanding for the level of care to which the patient is applying. A standard patient letter is provided to the patient or substitute decision maker, which confirms the level of care recommended by the team, and locations where this level of care is provided.

Re-Assessment Protocol for Sending Sites

To support patient flow and accuracy of the wait list, sending sites are responsible for reassessment of patients waiting for post-acute care. Change in patient medical or functional status or updated information is shared with CBA using the Patient Status Form. The information will be shared with the receiving sites.

If a patient is already on the waitlist for one program (e.g. rehab) and needs to be moved to another type (e.g. low intensity rehabilitation), a new referral is not required. The sending site will complete a Change in Status Form and new Letter of Understanding, and submit it together with the original application through CBA.

Bed Match, Medical Stability and Bed Offer

The receiving site will match patient to available bed and communicate directly with the sending site regarding patient medical stability and bed offer details. Transfer of Accountability is between sending and receiving site directly.

The sending site will inform patient and/or substitute decision maker of the bed offer. If the patient/substitute decision maker refuses the bed offer, the receiving site will proceed to the next appropriate application on the waiting list. The sending site will proceed with the discharge planning process with the patient to support transition to the

most appropriate destination that will meet their needs other than post-acute bedded level of care.

The central wait list is maintained by CBA using information submitted by the receiving site to confirm bed offer and patient admission.

Program Transfer

Request for Transfer Once Admitted

For shorter-duration programs (i.e., Rehabilitation, Low Intensity Rehabilitation and Activation/Restoration), transfer to another site is discouraged due to the impact on patient care. Requests for transfer will only be considered with agreement of both sending and receiving site. Conversation regarding transfer will be initiated with manager to manager communication. Transfer may only occur where there was a mutually agreed upon patient exchange, or an idle bed not matched to another applicant (i.e., there is no wait list).

Level of Care Transfer

Transfer is appropriate when a patient demonstrates eligibility for another bedded level of care managed by CBA, and the transfer will support achievement of patient goals. Transfer is initiated by submitting a Patient Status Update/ and Letter of Understanding to confirm patient consent. For transfer, patient may choose to apply to all sites providing the level of care, or if the patient’s current site offers the level of care to apply only to that site.

The patient will be match to an idle bed, if one available. In a wait list situation, the patient will be placed on the wait list for the current site only, or all sites if that is patient preference.

Bed Holding

Program	Bed Holding Guidelines
General Rehabilitation, Stroke Rehabilitation, Low Intensity Rehabilitation,	• Bed is held while patient is registered in ED. • If admitted to an acute care bed, the program bed is discharged on date of admission. • Patient may reapply once medically stable and meets the program criteria.
Activation/Restoration	• Bed is held while patient is registered in ED. • If admitted to an acute care bed, a bed at may be held for up to 7 days. • Acute care site to contact Activation/Restoration program to review patient. • **Exceptions on a case by case basis.**
Complex Care, including complex medical and palliative (pain & symptom management and end of life)	• Bed is held while patient is registered in ED. • If admitted to an acute care bed, the program bed is discharged on date of admission. • Patient may reapply once medically stable and meets the program criteria. • Exceptions on a case by case basis.
Complex Medical - chronic ventilator dependent	• Bed is held while patient is registered in ED. • If admitted to an acute care bed, the program bed may be held for up to 7 days provided that there is reasonable expectation of the patient returning to the program. • Acute care site to contact Complex Medical program to review patient situation. • Patient may reapply once medically stable and meets the program criteria. • Exceptions on a case by case basis.

Waterloo Wellington Repatriation Guidelines for Post-Acute Populations

In follow up to the Home First Steering Committee a separate repatriation working group was formed to develop common understanding across Waterloo Wellington regarding repatriation of patients between acute care hospitals and all post-acute programs. The working group was comprised of representatives from, Acute Care Hospitals, Post-acute Hospitals and at as named at that time Community Care Access Centre.

The guiding principles recommended by the members of the working group and the Home First Steering Committee are as follows:

Post Program:

Once a patient has completed the treatment program, goals have been met or patient has plateaued within program the post-acute program will not repatriate the patient to a higher level of health care provision (i.e. Acute Care) for the purpose of discharge planning. As an ongoing commitment Waterloo Wellington Acute Care Hospitals understand it is essential that discharge plans are initiated at the referring site and the referring site will ensure ongoing discussion with the family and/or caregiver has occurred and they understand the discharge plan.

Once admitted into the post-acute program, even if only for a few days, an overarching principle of not moving patients unnecessarily will be applied and the post-acute program team will begin discharge planning as per the Waterloo Wellington wide discharge planning policy. It is essential that only appropriate patient referrals are completed and sent from Acute Care Hospitals and that discharge planning discussions have started and the discharge destination is pre-established at the Acute Care site as per the Waterloo Wellington wide discharge planning policy.

Where patient arrives at a post-acute program, and their condition is such that they are unable to participate in the level of rehabilitative care, or where there are significant concerns with respect to the safety of the patient or other patients, return of the patient to the sending site will be accommodated. Conversation between unit managers and bed allocation/patient flow will be initiated to review patient situation and inter-facility transfer.

Within Program:

When a patient residing within the post-acute program requires emergent care that can only be met at an emergency department, the post-acute program will call 911 or facilitate a physician to physician phone call to arrange an assessment. The patient will be transferred to the emergency department in closest proximity to the post-acute program as per EMS protocol. The post-acute site should provide as much information with the patient as possible and if appropriate call the receiving emergency department to provide fulsome information prior to patient arrival. The bed holding policy as outlined in the Coordinated Bed Access Guiding Principles and Policies, will apply.

Where a patient is admitted to an acute hospital outside their home community, the patient will be considered for inter-facility transfer not repatriation. The discharge planning teams will initiate early planning as per the Waterloo Wellington discharge planning policy.

From Specialized Rehabilitation Program:

When a patient completes a specialized rehabilitation program (e.g., ABI, Oncology, Spinal Card), the patient will be repatriated to the Waterloo Wellington Hospital that signed the repatriation agreement with the specialized program. The site to which the patient is repatriated with complete discharge planning with the patient.

Bibliography

Rehabilitative Care Alliance. (2014, December). *Definitions Framework for Bedded Levels of Rehabilitative Care*. Retrieved from Home and Community Care, Waterloo Wellington Local Health Integration Network: http://healthcareathome.ca/ww/en/partner/Documents/Coordinated%20Bed%20Access%20%28CBA%29/Ref_Doc%20CBA_Definitions%20Framework%20for%20Bedded%20Levels%20of%20Rehab%20Care.pdf

Waterloo Wellington LHIN Home First Steering Committee. (2013). *Waterloo Wellington LHIN-wide Discharge Process Policies and Procedures. Home First Philosophy.*

Appendix A: Patient Transitions Steering Committee Membership

- Community Care Concepts
- Guelph General Hospital (GGH)
- Grand River Hospital (GRH)
- Groves Memorial Community Hospital (GMCH)
- Homewood Health Centre (HHC)
- St. Joseph's Health Centre Guelph (SJHCG)
- St. Mary's General Hospital
- Sunnyside Home, Region of Waterloo
- Community Care Concepts