Waterloo Wellington **LHIN**

Coordinated Bed Access Guiding Principles & Policies

Version 5.2

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Background

In 2011, Local Health Integration Networks and the Community Care Access CEO's, with Ministry support, committed to expand the role of CCAC, positioning CCAC 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 ensuring centralized and equitable access to post-acute bedded levels of care, including standardized eligibility determination (using established eligibility criteria and standardized referral tools), central management of the waiting lists, and a standardized discharge planning approach consistent with the Home First philosophy (Waterloo Wellington LHIN Home First Steering Committee, 2013).

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

- Rehabilitation,
- Low Intensity Rehabilitation,
- Activation/Restoration (including Convalescent Care),
- Complex Medical Management,
- End-of-life/Pain & Symptom Management Complex Continuing Care, and
- Residential Hospice.

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 Executive Group and Patient Transitions Steering Committee (Appendix B). This Guiding Principles document and any revisions are approved by the Chief Nursing Executives upon recommendation of the Patient Transitions Steering Committee.

The WWLHIN 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).

Levels of Care and Site Locations

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	Sunnyside Convalescent Care Groves Memorial Hospital
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 Live	Hospice Wellington Lisaard House Innisfree

Documents & Forms

This Guiding Principles and Policy document, and all associated documents and forms are posted to the WW LHIN Website: http://healthcareathome.ca/ww/en/Partners/coordinate-bed-access.

Roles and Responsibilities

CBA is responsible for:

- Management of waitlists for the identified programs.
- Reviewing incoming applications for field completeness and compliance with program service matrix.
- Notifying Sending Site if referral incomplete referrals, via a phone call and through twice daily Application Status reports
- Matching patients to appropriate beds in an accurate and timely manner.
- Requesting medical stability from sending site.
- Monitoring for receipt of medical stability within agreed upon timeline, or facilitating bed match to next appropriate applicant.
- Facilitating resolution conferences when requested.

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), and resolution conferences.
- Providing patient specific feedback using the Patient Transfer Feedback form.

The Receiving site is responsible for:

- Notifying CBA of all bed vacancy changes and updates.
- Reviewing matched applications for program appropriateness.
- Communicating with the sending site to resolve patient specific application concerns.
- Requesting medical stability from the sending site.
- Informing the sending site and CBA of acceptance and bed offer.
- Participating and contributing in site to site conversation to resolve application concern(s), and resolution conferences.
- Providing patient specific feedback using the Patient Transfer Feedback form.

Application & Acceptance to Waitlist

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

Applications will be processed based on waitlisted date and will include referrals from community and out of region. Applications for Specialized Rehabilitative Care Programs (i.e., Stroke) will be processed based on clinical care pathways. Applications for Palliative Care Programs will be processed based on wait list date and prioritized based on the palliative prioritization framework.

An application is completed by a sending site and submitted to CBA. CBA reviews the application for field completeness and compliance with the Program Matrix. Patient application is accepted to the wait list when application is complete. CBA will inform the sending site if an application is incomplete in compliance with the Program Matrix.

Site Specific Applications

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

- Patient clinical need can only be met at particular site(s) as per the 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 patient support system alone is not a reason for single site exception. This 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 on flow at their site. Each sending site will have an identified manager with responsibility for review and approval of site exceptions. See Appendix C for site exception process.

Patient Consent

Informed patient consent is required for application to a post-acute program, and for release of information to site(s) providing the program within the WWLHIN. 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 confirming the level of care recommended by the team, and the locations where this care is provided.

Re-assessment Protocol for Sending Sites

Sending sites are responsible to reassess patients on the waitlist to determine if their needs could be met in an alternative program. 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), then 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 to CBA.

Equitable Access to Service & First Avaliable Bed

Based on the WWLHIN wide prioritization framework, a patient may be matched to rehabilitation, low intensity rehabilitation, activation/restoration, or complex medical bed outside of their home community. Referral through CBA will enable matching of the patient to the first available bed in the region, or placement on the wait list for the post-acute bedded level of care until a vacancy occurs. In the case of multiple vacancies at the same time, geographic considerations of the patient/family will be applied during the matching process to facilitate care closer to home.

For Palliative beds, patients will be matched to their choice of site(s). The sending sites 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

Bed Match, Medical Stability and Bed Offer

This section applies to rehabilitative care programs only. CBA will match a patient upon receipt of a bed vacancy, and release the application to the receiving site. The receiving site will to review the application for program appropriateness and contact the sending site to resolve any patient application concerns. The receiving site will use the contact person listed as the Bed Offer Contact (page 1 of Acute Care to Rehab and Complex Continuing Care Referral) for communication with the sending site. If application concerns are not address, the process for patient bypass or refusal is followed by both sending and receiving sites (Appendix C).

Once application concerns are addressed, the receiving site will inform the sending site of patient acceptance to the program. The receiving site is then responsible for requesting medical stability:

- If admission is anticipated to be within in the next 24 hours, the receiving site will request medical stability at the time of patient acceptance.
- If admission is planned beyond the next 24 hours, the receiving site will contact the sending site 24 hours in advance of planned admission date to request medical stability.

The sending site is responsible for providing the medical stability to CBA within 3 hours of request by the sending site. The receiving site will make a bed offer by contacting the sending site, only upon receipt of medical stability. Receipt of medical stability by CBA will be considered confirmation of bed acceptance.

The sending site will inform patient/substitute decision maker of the bed offer. If the patient/substitute decision maker refuses transfer to the bed upon bed offer, CBA will proceed to the next person 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.

Medical Stability & Transfer of Accountability

Patient medical stability is essential for bed offer and transfer to a program. The sending site is responsible for providing information on patient medical stability and change in status using the appropriate documentation. If the patient is medically unstable at any time while waiting, or at the time that medical stability is requested, the sending site will submit a Change of Status Form.

Medical stability confirmation is required to be submitted by the sending site within 3 hours of request. A medical stability form is considered valid for 24 hours. Transfer of Accountability is verbal communication between sending and receiving nursing staff; and is to occur just prior to the patient leaving the sending site.

If medical stability is not received with three hours, or patient has become unstable:

- CBA will un-match the bed from the receiving site. The patient remains on the waitlist and the bed match process will start with the next available bed and the confirmation of medical stability form is received.
- CBA match next appropriate patient on waiting list, starting bed match process

again.
- In no-wait list situation, CBA will keep the patient matched to the receiving site until medical stability is received.

Patient Change in Status

It is the responsibility of the sending site to communicate timely change in patient status to CBA using the status update form. The status update form is use to:

- Report change in patient medical stability.
- Report change in patient functional status.
- Redirect the application to the most appropriate level of care.

Upon notification of medical instability, CBA will place patient 'on hold' for up to 7 days. If patient becomes medically stable within the 7 day period, the sending site will submit a status update form to CBA. If patient is *not* stable after 7 days, CBA will remove the patient from the waitlist and discharge the referral. CBA will notify the sending site that patient has been removed from the waitlist. The sending site may submit an application for the most appropriate program once the patient is once again medically stable.

Program Transfers and Bed Flexing

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 with demonstrated hardship to patient/family. 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/Program Transfer Request form 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 placed on the wait list for the current site only, or all sites if that is patient preference.

Bed Flexing (also referred to as Bed Spacing)

Bed flexing is an option available to receiving sites during idle bed situations only. An idle bed situation is defined as no applications in progress, on the waitlist or anticipated from sending sites). Beds may be flexed for the following purposes:

a) another CBA program (e.g., General Rehabilitation bed used as a Low Intensity Rehabilitation bed);
b) a patient who is no longer eligible for a post-acute bedded level of care (e.g., patient permitted to wait in hospital for LTC bed), or
c) a patient waiting for another bedded level of care (e.g., Low Intensity Rehabilitation patient waiting for Medically Complex pain and symptom management).

Bed flexing as outlined above for b) and c) is referred to "bed spacing" at some sites.

To flex a bed for purpose a), the receiving will first contact CBA to validate that there is no anticipated or waitlisted applications for that bed type. CBA and the receiving site will determine the most bed type to meet the needs of the system. The receiving site will inform CBA of the change in bed type by telephone and submission of the notification of bed vacancy form. CBA will match a patient to the bed.

To flex a bed for purpose b) or c), the receiving will first contact CBA to validate that there is no anticipated or waitlisted applications for that bed type. The receiving site will fill the bed. The receiving site will inform CBA by telephone and submit a notification of bed vacancy form.

In Bed Board Management (BBM), CBA will enter a flexed bed for purposed b) or c) as a 'suspended bed'. The sending site will notify CBA when the bed is no longer flexed (i.e., bed becomes available again as the original bed type) by submitting a notification of bed vacancy form.

Specific Referral Pathways

Chronic Assisted Ventilator Beds

Chronic Assisted Ventilator Complex Medical beds are located at Freeport. When there is a referral to one of these beds (regardless of the origin of the referral, i.e. out of region), CBA will share the entire referral (not just the minimum data set) with Freeport when the application is in an applied status. Freeport will review the application, and accept or deny the application in HPG. Only once the patient has been accepted to the waiting list will a patient be matched to a bed. Freeport will review of the ~~as~~ application as soon as possible in order to maintain an accurate waiting list.

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" and clearly indicate that the application is for stroke rehabilitation. CBA will use the "rehab ready date" to ensure stroke patients are not matched to a bed earlier than the indicated "rehab ready date". Stroke rehab applications are added to the rehabilitation wait list. CBA will first match stroke patients based on "rehab ready date" and then by wait list date.

Activation/Restoration Beds

Due to the wait time for activation/restoration beds, CBA will share the entire referral with Sunnyside and Groves when the application is in an applied status. The sites will review the application, and accept or deny the application in HPG. Only once the patient has been accepted to the waiting list will a patient be matched to a bed. Sunnyside and Groves will review the application as soon as possible in order to maintain an accurate waiting list.

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 CBA 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 Sunnyside bed may be held for up to 14 days as per the LTC Act; a bed at Groves may be held for up to 7 days. • Acute care site to contact Activation/Restoration program to review patient
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 CBA 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 CBA 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.

Repatriation Policy

See Appendix A for the WWLHIN wide policy on repatriation from sending to receiving sites.

Patient Transfer Feedback

Feedback among partner organizations promotes quality improvement and is encouraged. See Appendix C for Patient Transfer Feedback Process. Information on patient bypass, refusal, site specific applications and patient transfer is collected by CBA using the Patient Transfer Feedback Form.

Patient details are shared with sending and receiving sites involved for reflection and learning. Data is collected by CBA and analyzed for themes and improvement opportunities. Data is shared with Patient Transitions Steering Committee.

Metrics & Reporting

The following program and process reports are shared with CBA Partners on a regular basis.

Report	Program	Frequency
Idle Bed	Rehabilitation Low Intensity Rehabilitation Complex Medical Activation Restoration Palliative	Twice daily Monday to Friday Daily Saturday and Sunday
Application Status	Rehabilitation Low Intensity Rehabilitation Complex Medical Activation Restoration Palliative	Twice daily Monday to Friday Daily Saturday and Sunday
Referral Management Metrics	Rehabilitation Low Intensity Rehabilitation Complex Medical Activation Restoration Palliative	Monthly
Bed Management Metrics	Rehabilitation Low Intensity Rehabilitation Complex Medical Activation Restoration Palliative	Monthly
Program Refusals	Palliative	Monthly
Admitted to First Choice	Palliative	Monthly
Bypass, Refusal, Exception and Transfer Feedback trending	Rehabilitation Low Intensity Rehabilitation Complex Medical Activation Restoration	Quarterly

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 WWLHIN 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 WWLHIN regarding repatriation of patients between Acute Care hospitals and all post-acute programs. The working group was comprised of representatives from across WWLHIN, including Acute Care Hospitals, Post-acute Hospitals and WWLHIN.

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 be repatriating to a higher level of health care provision (i.e. Acute Care) for the purpose of discharge planning. As an ongoing commitment WWLHIN 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 CC team will begin discharge planning as per WWLHIN 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 WWLHIN wide discharge planning policy.

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.

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.

Appendix B Patient Transitions Steering Committee Membership

- Waterloo Wellington Local Health Integration Network (WWLHIN)
- Cambridge Memorial Hospital (CMH)
- 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

Appendix C: CBA Patient Transfer Feedback Processes

The following document outlines the processes for bypass, exception, refusal and patient transfer feedback.

http://healthcareathome.ca/ww/en/Partners/coordinate-bed-access

Waterloo Wellington **LHIN**

141 Weber St. S.
Waterloo, ON N2J 2A9
Tel: 519 748 2222 • Fax: 519 883 5500
Toll Free: 888 883 3313
www.waterloowellingtonlhin.on.ca

Ontario
Local Health Integration Network