QUICK REFERENCE TO ACCESS THE REINTEGRATION CARE UNITS THROUGH CENTRALIZED REFERRAL MANAGEMENT (CRM)

This "Tip Sheet" has been developed as a quick ***reference tool*** to support hospitals in transitioning patients to the Reintegration Care Units (RCU) in a timely, safe, efficient and effective manner.

Referrals to access any of the bedded capacity programs (see below) are reviewed for eligibility and matched to an appropriate program vacancy by a Centralized Referral Management (CRM) Team that are responsible for:

1. Ensuring the referral received from hospital partner is complete and the patient meets the eligibility criteria.

2. Maintaining flow in the RCUs through timely matching of all referrals. 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. Timely communication to hospital partners (one to three business hours) regarding the status of submitted referrals.

4. Obtaining vacancy and capacity status for each participating program partner, maintaining oversight of overall bed capacity and referral status, as well as responsibility for reporting all data/metrics to funding and health system partners.

5. Providing telephone and e-mail consultations to hospital partners in regards to potential patients they would like to refer to an RCU Service and providing further navigation and information, as needed, prior to referral of patient to the RCU.

What are Reintegration Care Units (RCU)s?

The Reintegration Care Units (RCUs) is one of the short-term transitional programs in Toronto Region 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.

	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. **Each RCU has 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.

Who are the HSP partners operating the RCUs and how many beds do they have?

RCU HSP PARTNER	TYPE OF RCU	TOTAL CAPACITY	TYPE OF UNIT
BELLWOODS	Independent Living RCU	15	Apartment Units
HILLCREST REACTIVATION CENTRE	Congregate Facility RCU	66	Beds
LES CENTRES D"ACCUEIL HERITAGE (** FRANCOPHONE PATIENTS ONLY)	Independent Living RCU	2**	Apartment Units
LOFT COMMUNITY SERVICES (PINE VILLA)	Mental Health Congregate RCU	34	Beds
LOFT COMMUNITY SERVICES (WHITE SQUIRREL WAY)	Mental Health Congregate RCU	12	Beds
RECONNECT COMMUNITY HEALTH SERVICES	Congregate RCU and Independent Living Units	17	Beds (14) Apartment Units (3)
SPRINT SENIOR CARE (PINE VILLA)	Congregate RCU	34	Beds
UHN TCP AT QUEEN'S ESTATE	Congregate RCU	9	Beds
THE NEIGHBOURHOOD GROUP	Independent Living RCU	10	Apartment Units

Who is eligible for referral to an RCU?

Basic Eligibility 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). 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 an RCU?

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 or phone 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. There are also limited beds within RCU to support clients with significant mental health challenges and needing hoyer lifts and thus clients may be put on an internal waitlist that is monitored.

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 the RCU programs are the right resource.

Standard Referral Process

1. **Complete the full referral form.** The latest version is available on the CRM webpage at http://bellwoodscentres.org/. The CRM webpage can be accessed under "Reintegration Care Units" on the yellow homepage banner.

2. As per the instructions on page 1 of the referral form, please send **the completed referral form to Centralized Referral Management** via fax: 365-300-5758 (Toronto Area) or email attachment to: crm.team@bcclsp.org. Please ensure your referral information is complete and accurate.

3. The CRM team will **review** and **match** your patient to an RCU vacancy. If additional information is required, the CRM Coordinator will contact the referral source to clarify and facilitate the acquisition of information required to successfully match the patient. We maintain waitlists specifically for client's who require specialized supports, such as mental/behavioral units, 2person mechanical lifts, and for whom LTC is their discharge destination.

4. Referrals are prioritized for matching through CRM based on:

    a. Time: each referral received is prioritized based on time they were received
    b. Available vacancies/patient profile: patient needs and availability/suitability of RCU environment

c. Surge: referrals received from hospitals declared to be in surge, are prioritized for matching to vacancies.

5. Once all the information is complete and meets the program criteria, you will receive a confirmation by email of who the RCU provider is the client has been matched to and the "next steps" required to facilitate admission to the RCU as quickly as possible. If information is missing or 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 be notified within one to three business hours.

6. **If the patient is matched, the RCU Team will work with you to plan the quickest transition possible**. The RCU partner receiving the referral will contact the hospital referring partner to complete their intake process and coordinate directly with the hospital to facilitate a timely transition to their RCU. Ensuring a safe, timely and effective transition is the CRM and RCUs priority; therefore, the RCU will contact you to plan to move the patient to the RCU as quickly as is feasible to facilitate an effective, safe transition to RCU.

What are the roles and responsibilities of all partners when a hospital partner is in surge?

To ensure a proactive response to hospitals experiencing surge or high occupancies, the following clarification of roles is proposed:

- Hospital partner in surge will:
  - Identify a key contact for CRM to work with to: complete referral, maintain ongoing communication to obtain information required to facilitate matching/communicate status and act as a central person to coordinate any information sharing/consents etc. as required to facilitate matching/timely transitions.
  - Obtain Consent for referral and transition to an RCU from patient or their substitute decision maker
  - Provide timely, transparent, accurate and complete referral information for each referred patient to facilitate timely and effective matching. Risks will be clearly highlighted for CRM coordinator (e.g. 2-person mechanical lift, wandering, mental health/substance use challenges, or lack of a discharge destination from RCU)
  - Focus on referring patients that are returning to a community destination post RCU stay (not destined for LTC or require LTC as a discharge destination) to promote overall RCU flow.
- CRM will:
  - Immediately alert RCU HSP partners of Surge status and the hospital site
  - Prioritize all referrals from Surge Sites over any other referral received. Ontario Health leadership Team may even advice that a certain # of beds are to be held.
  - Connect with hospital partner to facilitate the exchange of information required to facilitate matching to an appropriate vacancy
  - Monitor status of referrals and ensure referrals matched from hospital in Surge are all admitted within 24-48 hours (usually not over weekends, but some exceptions have been made, site by site) of referral
  - Report on key indicators to monitor the efficiency and effectiveness of outcomes of this process and referral management for reporting into the ALC Command Table
- RCU Partner will:

- Upon receiving Surge alert from CRM, immediately confirm their vacancy status with CRM.
- If they have received a referral from a Surge site, hold/suspend all intake activities for pending referrals from other hospital referral sites and prioritize time and attention to the referrals received from the Surge hospital partner
- Will connect with hospital referrer and facilitate admission to their facility within 24 – 48 hours if hospital provides the adequate additional information.
- If HSP partner believes the patient may not be appropriate for their site, or there are concerns re: additional care needs beyond what the site can offer, they will immediately contact CRM to discuss what they need to accept the referral. The CRM Community Resource Navigator will connect with RCU partner intake coordinator to discuss concerns about applicant eligibility in order to obtain information re: what site would need in order to accept the patient.

How will CRM modify the standard process for hospitals identified to be in Surge?

1. CRM will notify all RCU partners of hospital in surge to alert them to prioritize all referrals received from that hospital and confirm vacancies/capacity at their site.
2. Contact Hospital referral key contact to discuss candidates and facilitate referral submissions.
3. All eligible, complete referrals will be matched and sent to an RCU provider within 30 minutes of receiving them through CRM to RCU provider as per RCU referral standard matching criteria.
4. Any ineligible or incomplete referrals will trigger an immediate call to the hospital referring partner's key site contact to facilitate completion or further discussion of transition options/supports required to promote successful matching to a vacancy.
5. If referral volumes from hospital site exceed the threshold of vacancies offered to the site, referrals will be prioritized on:
    a. Fit to existing RCU vacancy criteria
    b. Time received
6. Referrals matched and received by the RCU partner intake coordinator will be reviewed, assessed and accepted within one business day.
7. If an RCU partner determines (based on their intake assessment) that will not be able to safely accommodate the patient's needs, ***they will identify the additional supports they would require to take the patient to CRM prior to breaking the match.***
8. CRM will work with the RCU and hospital partner to complete a transition plan that outlines the supports requested and forward that to the VP of Transitions for discussion with ALC Command Table partners.
9. If a referral is best suited for an RCU partner that does not currently have capacity, the CRM coordinator will contact the site to problem solve whether capacity can be unlocked through inter-RCU transition or other strategy.
10. The ALC Command Table partners will provide decision making and explore system resources that unlock the barriers to support transition.
11. CRM will also identify alternative recommendations to support the safe and timely transition of the patient from hospital to another destination.

12. CRM will provide an update at the end of day to the VP Transitions of the status of the referrals and transitions for the hospital site in surge. As well, CRM will highlight any other unintended delays to other referrals through CRM for other hospital sites.
13. VP Transitions will provide daily updates to the ALC Command Table Lead, System Capacity and Flow

APPENDIX 1: EXAMPLES OF PATIENTS WHO HAVE BEEN SUCCESSFULLY TRANSITIONED

PATIENT COHORTS	DESCRIPTION OF PATIENTS ADMITTED TO RCUS
ACUTE CARE HOSPITALS **POST-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).
SOCIAL / HOUSING NEEDS	▪ 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 awaiting move to new 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 before returning to shelter. **Please note, if patient is moving to a new housing arrangement post-RCU, there should BE CONFIRMATION BY hospital team of LOCATION and ALL finance/PAPERWORK NECESSARY NEEDS TO BE COMPLETED as social work support and/or discharge planning is NOT consistently available in the RCU setting.*