GTA Rehab Network and Rehabilitative Care Alliance (RCA) Resources to Support the OH Operational Direction for Rehab and CCC

The Operational Direction Rehabilitation and Complex Continuing Care Capacity and Flow guidance document issued by Ontario Health (OH) on July 12 2023 refers to a number of resources developed by the GTA Rehab Network and Rehabilitative Care Alliance (RCA). The following table sets out the relevant OH recommendations in the guidance document and the links to the associated resources.

Setting	OH Recommendation	GTA Rehab Network / RCA Resources
All hospitals	All hospitals will work towards achieving ALC throughput targets of >1. Implement guideline 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. (p4)	GTA Rehab Network Inter-Organizational Transfer of Accountability Guideline Guideline provides six principles that support the interactive process of transferring information and coordinating follow-up care between organizations across the patient lifespan and care continuum. RCA & PGLO Rehab Care for Older Adults Living With/At Risk for Frailty: From Frailty to Resilience Framework Sets out core elements and processes of care required when providing rehabilitative care to older adults living with/at risk of frailty, recommended best practices and how to implement them within specific domains of care Webinar & Presentation: From Frailty to Resilience: Rehabilitative Care Preventing & Mitigating Alternate Level of Care
Acute Care Hospitals	Ensure a proper discharge plan is established and communicated to rehab and CCC hospitals/bedded programs and other discharge destinations (p3)	GTA Rehab Network Discharge Checklist Outlines key information that should be provided at the time of transfer to the next level of care (to hospital or community) in order to support patient safety and continuity of care.
Acute care hospitals	Align referral processes with the Provincial Referral Standards Reference Guide. Note: patients do not need to be designated ALC for a referral to take place. (p5)	GTA Rehab Network Referral Guideline for Bedded Levels of Rehabilitative Care Guideline provides criteria to determine eligibility for bedded/inpatient rehabilitative care, including criteria for rehab readiness, ALC designation, and

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		timing and number of referrals to submit. It also includes new criteria for timing of response to referrals, requests for information and 'admission' of patients within Resource Matching & Referral (if used). Provincial Referral Standards Reference Guide This referral reference guide complements the updated Provincial Referral Standards (referral form) to support consistency in the understanding and submission of referral information from acute care to bedded (inpatient) levels of rehabilitative care and Complex Continuing Care (CCC).
Rehab and CCC hospitals/facilities/bedded programs	Ensure bed holding policies align with guidance to support the repatriation of patients to bedded levels of rehabilitative care to optimize bed capacity in the post-acute system (p3)	Guidance to support the Repatriation of Patients to Bedded Levels of Rehabilitative Care in Freestanding Rehab/Complex Continuing Care Hospitals. Draws on the GTA Rehab Network's bed holding policy and provides supplemental guidance developed with the GTA IMS planning and command tables to optimize bed capacity in the post-acute system in response to surge capacity pressures.
	Adopt flexible admission criteria to accommodate patients on the wait list for rehab and CCC and respond to changing demand. Consider off-service admissions and mixed units for non-specialized programs to enable opportunities to flex resources between different bed types (p3)	RCA Framework for Bedded Levels of Rehabilitative Care Framework defines four bedded levels of rehabilitative care: Rehabilitation Activation/ Restoration, Short-term and Long-term Complex Medical Management
Rehab and CCC hospitals/facilities/bedded programs	Follow best practices in rehabilitative care as outlined in best practice documents for key populations with the following conditions including hip fracture,	Rehabilitative Care for Older Adults Living With/At Risk of Frailty: From Frailty to Resilience RCA Hip Fracture: Addendum to Rehabilitative Care for Older Adults Living

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	older adults with frailty, total joint replacements (p5)	With/At Risk of Frailty: From Frailty to Resilience The above documents, together, provide rehabilitative care best practices for all older adults with frailty, including those with hip fracture, and additional recommendations specific to hip fracture
Rehab and CCC hospitals/facilities/bedded programs		RCA & PGLO Rehab Care for Older Adults Living With/At Risk for Frailty: From Frailty to Resilience Framework Outlines recommended best practices and how to implement them within specific domains and processes of care that directly align with the ALC Leading Practices and senior friendly care. See also: Webinar & Presentation Older Adults Living With/At Risk of Frailty: Gap Analysis Tool Tool to understand current state of rehab services for older adults and provide the mechanism through which systems, organizations, and services can begin to operationalize the Core Elements of Care and Processes of Care described within the RCA/PGLO older adult framework. See also Webinar & Presentation For additional resources on rehab guidelines for the older adult, see https://rehabcarealliance.ca/older-adults-with-frailty-rehab-guidelines/.

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Rehab and CCC hospitals/facilities/bedded programs		RCA Rehabilitative Care Best Practices for Patients with Hip & Knee Replacement Best practice framework, referral decision tree, and process indicators to support performance monitoring of bundled care-related outcomes. For additional Hip Fracture Rehab resources see: https://rehabcarealliance.ca/hip-fracture-rehab-resources/ This collection of evidence-based tools and resources is provided to support best practice rehabilitative care across the continuum for frail seniors with hip fracture Total Joint Replacement Quick Reference Guides Based on the full framework above. Provides a concise summary of best practices to guide clinical practice in each setting (Pre-operative care, acute care, bedded levels of rehabilitation, outpatient/community clinics) For additional TJR Rehab resources, see https://rehabcarealliance.ca/tjr-rehab-resources/ This collection of evidence-based tools and resources is provided to support best practice rehabilitative care across the continuum for people with total joint replacement (hip or knee)
Rehab and CCC hospitals/facilities/bedded programs	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. (p6)	Direct Access Priority Process (DAPP) Tools Looks at older adults 65+ who present with a change in function relative to baseline with prompting questions: (i) What has changed? (ii) How has it changed? (iii) Why has it changed?

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		Outlines referral pathways to the most appropriate level of rehabilitative care Checklist to Rule Out Acute Causes of Functional Decline Provides guidance on answering the following question from the DAPP: "Is there an acute medical cause for functional decline?" For additional tools & resources, see https://rehabcarealliance.ca/frail-seniors/direct-access-priority-process-dapp/