

Repatriation Policy Implementation Guideline

The purpose of the [Policy for the Repatriation of Patients to Bedded Levels of Rehabilitative Care in Freestanding Rehab / Complex Continuing Care Hospitals, April 2017](#) (henceforth referred to as Repatriation Policy) is to support patient-centred care and optimize patient flow.

This guideline provides supplemental information for the Repatriation Policy to support consistency in the communication practices and implementation of the policy across organizations.

The successful transition of patients between organizations relies heavily on *regular and ongoing communication* between the rehab or CCC program and acute care to discuss the patient's status, progress and readiness for return to the rehab or CCC program.

1. Transfer of accountability – Inpatient Rehab/CCC to Acute Care

At the time that a patient is transferred from rehab/CCC and re-admitted to acute care, the rehab/CCC hospital will fully complete and send the EMS Patient Transfer Form. This form is available on rehab/CCC units.

2. Considerations for Bed Holding for the Long-Stay Patient in CCC

In the event that a patient has resided in CCC *for many years*, pays a co-payment and is considered to be “more or less a permanent resident in the hospital”¹ in absence of appropriate residential/LTC options in the community, the holding of beds, when appropriate, supports patient-centred care and respects the therapeutic relationships that have been developed between the care team and the patient.

For patients within these circumstances, there needs to be very clear communication between the rehab/CCC hospital and acute care re: the estimated time for holding the bed given the patient's emergent acute care needs and the principles of patient-centred care.

Information on the application of the chronic care co-payment provisions:²

Question: Is the chronic care co-payment applicable to those patients who have been designated as requiring chronic care and more or less permanently resident in the hospital or other institution, but at some time following that designation require acute care services?

It is anticipated that chronic care patients may be hospitalized for many years. During this period of hospitalization, unanticipated acute episodes may occur, such as pneumonia, heart attack, etc. If the patient requires acute care or some other type of care but still requires chronic care and will be more or less permanently resident in the hospital, the co-payment remains applicable.

However, if the attending physician is of the opinion that the patient no longer requires chronic care for a period of time, the co-payment cannot be charged during that period of time.

¹ MOHLTC, Hospital Complex Continuing Care (CCC) Co-payment, Questions and Answers, Resource to LHINs and Hospitals, Updated May 2010.

² From Hospital Chronic Care Co-Payment/Questions and Answers. Retrieved from <http://www.health.gov.on.ca/en/public/publications/chronic/chronic.aspx#beds>, Dec 22 2017

3. Communication regarding the release of the rehab/CCC bed

- The responsibility for informing patients/caregivers about the release of beds as per the Repatriation Policy lies with both acute care and rehab/CCC hospitals.
- Rehab/CCC to provide specific information regarding the repatriation policy and management of patient belongings before a patient is discharged and transferred to acute care, if possible. It is up to the discretion of the rehab/CCC hospital to determine when this information is best communicated to the patient and/or caregiver. The verbal communication with patient/caregivers can be supplemented with written information.
- *If a patient is admitted to acute care before communication* about the repatriation policy and management of patient belongings can be provided to the patient and/or caregiver, the rehab/CCC hospital will contact the acute care team to determine how/when this information will be given to the patient and/or caregiver.
- If possible, the rehab/CCC hospital to provide acute care with a general sense as to how long a patient might need to wait to return to the program.

4. Process for patients already designated as ALC in rehab/CCC when repatriated to acute care

- A previous designation of ALC in rehab/CCC is not a sufficient reason to refuse to repatriate a patient back to the rehab/CCC program.
- However, there are 2 situations where readmission to rehab/CCC is not recommended:
 - The patient's medical care needs can no longer be accommodated
 - A patient's discharge destination is "home" and the discharge plans previously arranged by rehab/CCC still apply and can be enacted by acute care. Under these conditions, re-admission to rehab/CCC would constitute an unnecessary second transfer and could result in an unnecessary delay in discharge. As such, acute care will enact the discharge plans and discharge the patient home directly from acute care.

5. Transfer of accountability – Acute Care to Inpatient Rehab/CCC

a) Requirements for an update

- When a patient is re-admitted to acute care, an update only along with documentation regarding medical status and medications (MAR) is required if the patient:
 - Has been admitted to acute care for less than 2 weeks *and*
 - Has had no change in his/her functional status.
- The update will be used by the rehab/CCC program to confirm the following:
 - the patient continues to meet the admission criteria of the rehab or CCC program from where the patient was transferred
 - patient's readiness to return to rehab or CCC program
 - current medication needs

- If there is no change in the patient's functional status and there was no referral to allied health for re-assessment during the acute care stay, acute care is required to clearly communicate this to the rehab or CCC program.

b) Requirements for a functional re-assessment

- When a patient is re-admitted to acute care, a functional re-assessment is required if a patient:
 - has been admitted to acute care for less than 2 weeks *and*
 - has had a change in functional status *and*
 - continues to meet the admission criteria of the rehab or CCC program from where the patient was transferred
- Send an update, using current processes on interventions provided during the acute care stay including the medical and functional updates, i.e., new medical needs, including lab results, changes in medication, nursing notes, etc.

c) Requirements for a new referral

- When a patient is re-admitted to acute care, a new referral is required if a patient:
 - has been in acute care for more than 2 weeks* *or*
 - has received a new medical diagnosis affecting physical/cognitive function *or*
 - requires a different rehab/CCC program
- A new referral is to be completed and submitted using existing organizational process (e.g., through RM&R; submission of paper-based [GTA Rehab Network Integrated Acute Care to Inpatient Rehab/CCC Referral Form](#)).

*NOTE 1: For a planned admission that results in an acute care admission for longer than 2 weeks, a new referral may not be required and should be determined in consultation with the rehab/CCC program.

*NOTE 2: There may be circumstances in which a new referral is not needed for an unplanned admission of more than 2 weeks (e.g., for a Long Stay patient of a rehab/CCC organization). However, this should be determined in consultation with the rehab/CCC program.