GTA REHAB Network

Environmental Scan of Short-Term Transitional Care Models

October 2020

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Background

Purpose of the Environmental Scan

From February to July 2020, the GTA Rehab Network undertook an environmental scan of Short-Term Transitional Care Models (STTCMs) that provide a bedded level of care with a rehabilitative component. This report provides an overview of how rehabilitative care is integrated within these emerging models to help providers better understand the role of STTCMs within the rehabilitative care landscape.

About Short-Term Transitional Care Models

STTCMs have been established with the purpose of providing temporary care and accommodation in settings outside hospitals for patients designated ALC while they await discharge back home or to a more appropriate facility.[1] They were enabled by a $62 million investment from the Ministry of Health in 2018/19, which supported establishment of 66 STTCMs across the province.[1] The STTCM include the following service delivery models:

- Home and community care services (36 programs)
- Specialized supports/enhanced care coordination in hospital (14 programs)
- Community-based specialized mental health and paramedicine services (nine programs and services)
- Intensive support in Long Term Care Homes (two teams)
- Primary care in the community (one program)
- Transportation and service provider training (four programs)

Additional funding was secured for STTCMs in 2019/20 through the Ministry of Health's 10-year reinvestment of $27 billion in new or expanded hospital infrastructure.[2]

The STTCMs reviewed in this report provide care using the first two service delivery models noted above (i.e., home and community care services and specialized

[1] Ministry of Health, Capacity Planning and Priorities Branch (2019, May 29). *Short-Term transitional Care Models*. Presentation by the Ministry of Health at the OHA CCC-Rehab Provincial Leadership Council at the Ontario Hospital Association, Toronto, Ontario.

[2] Ministry of Health (2019, July 11). Ontario Opening More Transitional Care Beds in the Greater Toronto Area. Investments in Innovative Frontline Care Models Will Help End Hallway Health Care. https://news.ontario.ca/mohltc/en/2019/07/ontario-opening-more-transitional-care-beds-in-the-greater-toronto-area.html

supports/enhanced care coordination in hospital). In the Greater Toronto Area, STTCMs were focused on reopening legacy hospital sites and in some cases, collaborating with community providers to create spaces that provide an interim level of care for patients who are waiting to transition back home to the community or long-term care (LTC). This interim level of care included both nursing care and therapeutic programming focused on promoting social interaction, activity and functional improvement.[2]

Short-Term Transitional Care Models in the GTA

Inclusion Criteria

All STTCMs included in the environmental scan have a bedded program with a rehabilitative care component and are located in the Greater Toronto Area. In total, 13 STTCM programs were reviewed.

Methodology

Key contacts from individual STTCMs were interviewed twice from March to July 2020 (before and during the COVID-19 pandemic). Information was compiled in a table (see Appendix) and sent back to key contacts for validation before the final report was produced. Evaluations of the reviewed STTCM programs were not available to the GTA Rehab Network and consequently were not included in the environmental scan.

Description of the Models

All STTCM models reviewed involve GTA Rehab Network member organizations working in collaboration with each other and/or a community service provider. These models can be categorized into two types of programs: those with acute care beds and those with community beds.[3] The key differences between acute care and community programs include the following:

[3] Community beds is a simplified term used for this report for ease of reading. It refers to all STTCMs that have clinical care reintegration beds or community beds/spaces.

- **Patient admission status** – Patients transferred to acute care programs continue to be patients of the hospital of origin, while those transferred to community programs are discharged from the hospital of origin.
- **Staff providing care** – Acute care programs are staffed by acute care employees, while community care programs are staffed by community service providers.
- **Complement of allied health staff** – Acute care programs have a full complement of allied health staff that includes physiotherapists, occupational therapists, social workers, speech language pathologists, registered dietitians, pharmacists and recreational therapists. By contrast, most, but not all of the community programs only have physiotherapists, occupational therapists, recreational therapists and social workers. Additional allied health staff are provided by LHIN home and community care when needed.
- **Number of bed/spaces** – Community programs have smaller capacity (10-20 beds).

There are no consistent differences between acute care and community programs in the types of patients admitted, frequency and duration of rehabilitative care services, length of stay or discharge destination. The two types of programs are described in more detail below.

1. Acute care programs

Acute care programs are funded by the Ministry of Health as a specialized support in hospital[1]. The majority of STTCMs reviewed fall into this category (eight out of 13 programs). All acute care programs reviewed have beds located in Humber River Church and/or Finch legacy hospital sites. Humber River Hospital is the landlord for all programs housed in these legacy sites, while each program (i.e., each unit) is staffed and operated by a different acute care hospital. Patients are referred through an internal process, based on an internal set of criteria that includes an ALC designation with a confirmed discharge destination. Patients are admitted only to the units operated by their hospital of origin. These programs do not accept referrals from external sources.

Patients are provided with recreational and rehabilitative care activities throughout their stay. Activities are available six to seven days/week; however, the level of participation depends on the individual's ability and tolerance. Rehabilitative care is provided by allied health professionals including physiotherapists, occupational

therapists, speech language therapists, social workers, therapy assistants and recreational therapists. Individual programs vary in their complement and number of allied health professionals (see Appendix for detailed breakdown per program). All programs have access to gyms and equipment (see Appendix for details).

Patients do not have any out-of-pocket costs besides the per diem ALC co-payment for those awaiting LTC placement.

2. Community programs

Community programs are funded by the Ministry of Health as a home and community care program.[1] Five programs were reviewed as a part of this report, as the inclusion criteria was focused on bedded rehabilitative care. These programs are typically located in retirement homes, assisted/group living facilities, and in one case, a legacy hospital site (i.e., UHN Hillcrest). Each program is established in partnership by a hospital/hospital network and a community service provider, with the latter being responsible for the clinical staffing. Patients are referred through an internal process, typically involving a dialogue between a referring organization and the STTCM to ensure patient care needs can be adequately met. Three of the five programs accept referrals from external organizations, with two only accepting patients from Toronto Hospitals (Hillcrest Reactivation Care Centre and St. Hilda's Senior Care Community Reactivation Care Centre) at no out-of-pocket cost to patient, and one with a per diem cost to patient (Carefirst Transitional Care Model).

Patients are provided with recreational and rehabilitative care activities throughout their stay. Activities are available six to seven days/week, with a strong focus on social/recreational programing and some rehabilitation. The level of activity provided for each patient depends on their individual ability and tolerance. Rehabilitative care is provided by the community service provider's own allied health professionals or contracted through LHIN Home and Community Care (see Appendix for detailed breakdown per program). The allied health staffing component is not as diverse as that seen in STTCM acute care models. In some programs, small equipment pools are available (see Appendix for details).

Patients are not charged a per diem fee but are responsible for personal costs such as medication and incontinence products.

Programs Reviewed

Each program is described in the tables in the Appendix. Acute care programs include:

- Humber River Reactivation Care Centre (pages 11 and 12)
- Mackenzie Health Reactivation Care Centre (pages 13 and 14)
- Markham Stouffville Reactivation Care Centre (page 15)
- North York General Hospital Health Reactivation Care Centre (page 16)
- Southlake Regional Health Centre Reactivation Care Centre (page 17)
- Sunnybrook Health Sciences Centre Reactivation Care Centre (page 18)
- St. Joseph's Health Centre Reactivation Care Centre (page 19)
- Trillium Health Partners Reactivation Care Centre (page 20)

Community programs include:

- Carefirst Transitional Care Model (page 21)
- Hillcrest Reactivation Care Centre (page 22)
- Lakeridge Health Transitional Care Models (page 23)
- North York General Hospital Transitional Care Unit at Queen's Estates (page 24)
- St. Hilda's Senior Care Community Reactivation Care Centre (page 25)

Analysis

While the focus of STTCMs is addressing hospital capacity challenges,[2] they also provide an opportunity in the system for patients to access rehabilitative care. Rehabilitative care in STTCMs is focused on re-activation, or more specifically, on promoting social and physical activity, with an aim to improve or restore function and independence. There are similarities between the reviewed STTCM programs and convalescent care provided in Long Term Care Homes based on layouts of the units, frequency and type of rehabilitative care programming, and availability of allied health staff. These similarities were also noted by some STTCM providers during the interviews. In some instances, STTCMs were preferred by acute care hospitals over convalescent care programs due to ease of application process and more timely admissions.

Most of the STTCMs reviewed fall in the acute care program category. There are parallels between the STTCM beds and ALC or transitional units/beds in acute care hospitals. However, the key difference is in the medical complexity they can support.

STTCMs are located outside of acute care hospitals and do not have access to the same clinical resources required to support patients with higher levels of medical complexity (see Appendix for details on exclusion criteria for each program).

The amount of rehab provided across different acute care STTCMs programs is similar. Most of these programs include a full complement of allied health staff. By contrast, most community care programs have occupational therapists, physiotherapists, recreational therapists and social workers, but require referrals to LHIN Home and Community Care for additional interventions.

In both acute care and community care programs, the frequency of group and one-to-one interactions is varied and dependent on patients' ability to participate. On average, patients may be provided with one-to-one rehab sessions from two to a maximum of five times/week for 15 minutes and group recreational sessions five times/week for 30 minutes. (Note: Group activities have been put on hold as a result of the COVID-19 pandemic, see page 5.) As reported in the interviews, the intensity of rehab intervention is less than that in high and low intensity rehab programs.

The level of rehabilitative care in STTCMs appears to align with the Activation/Restoration level in the Rehabilitative Care Alliance's *Definitions Framework for Bedded Levels of Rehabilitative Care*. As stated in the Definitions Framework, the goal of the Activation/Restoration level is to "promote activity, increase strength, endurance, independence and ability to manage activities of daily living by providing access to therapies with a focus on restoring function. These include functional practice opportunities, wellness and self-care activities that support the return of patients to their previous living environment or other appropriate community environment."[4] However, the key difference between the Activation/Restoration level of care and STTCMs is the anticipated discharge destination. Unlike Activation/Restoration programs, STTCMs allow for patients to be discharged to LTC homes. Other discharge destinations align with the Activation/Restoration programs and include home, home with services, congregate living spaces, retirement homes and rehab facilities.

[4] Rehabilitative Care Alliance (2014, December). Definitions Framework for Bedded Levels of Rehabilitative Care. http://rehabcarealliance.ca/uploads/File/Toolbox/Definitions/Definitions_Framework_for_Bedded_Levels_of_Rehabilitative_Care__FINAL_Dec_2014_.pdf

Impact of COVID-19 Pandemic

The impact of the COVID-19 pandemic was similar across different STTCMs. In the early stages of the pandemic. the priority was creating capacity in acute care. Consequently, STTCMs adjusted their admission criteria, where safe and appropriate (e.g., admitting patients without a discharge destination). Some programs experienced outbreaks, particularly in the early stages of the pandemic, as Infection Prevention and Control (IPAC) protocols and public health guidance were evolving. Some STTCMs had reduced their bed capacity in order to accommodate 14-day insolation for new admissions (see Appendix for details on programs that have ongoing capacity changes). Rehabilitative care services had to be reduced with group therapy transitioning to one-to-one sessions in patients' rooms in order to follow IPAC protocols. Use of hallways or stairwells as part of therapy was limited due to IPAC protocols. Recreation activities were also transitioned to one-to-one sessions, and often the time was used to virtually connect patients to their families.

Further adjustments included repurposing of shared spaces into client/patient rooms, replacing in-person visitations with video transactions through use of iPads and replacing congregate dining with in-room meal tray service.

Challenges were experienced by all STTCMs in discharging patients to retirement homes and LTC as a result of outbreaks and MOH guidelines. Some STTCMs also reported initial challenges with discharges to the community, especially in the beginning stages of the COVID-19 pandemic. These challenges included limited availability of personal support workers in the community, increased caregiver anxiety associated with different service providers entering the home, and primary caregivers recovering from COVID-19. At the time of the follow-up interviews conducted in June and July of 2020, initial challenges with discharging patients into the community with services had been largely resolved.

As the province began staged reopening, STTCMs strategized on re-introducing in-person visitation with designated days, times and specific location (i.e., gym); providing group activities with a small, limited number of participants (e.g., five participants); and staggering recreational/rehabilitation group sessions. Future considerations and challenges include supporting increased hours for in-person visitation, increasing group activities and allowing patients' personal belongings to be brought into the units.

Final Thoughts

STTCMs appear to fulfill their main purpose of addressing capacity challenges in acute care hospitals in the Greater Toronto Area. They also provide an additional opportunity for patients to access rehabilitative care in the system. However, the duration and frequency of rehabilitation appears to be lower than that seen in high- and low-intensity rehabilitative care programs and aligns more with convalescent care models.

Appendix: Short-Term Transitional Care Models Reviewed

Acute Care Programs (pages 11-20)

Humber River Hospital Reactivation Care Centre – Finch and Church Sites

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
Humber River Hospital Reactivation Care Centre	Humber River Hospital	30 beds – Humber Finch site	Internal referrals only	Internal referrals only: • ALC status with confirmed discharge destination • Medically stable • Cleared by IPAC • Restorative potential • Dialysis only available at Church site • IV hydration and first dose Abx available Exclusion criteria: certain medical complexities (frequent transfusion, wounds > stage 3, ventilator, suction, bariatric, patient behaviours are risk to patient/staff injury, elopement risk, involuntary admission)	**Common patient group:** varied **Target LOS:** varied **Activities:** organized activities available 7 days/week **Common discharge destination:** varied **Layout:** hospital, shared dining room and activity room **Activities:** group and individual activities (including hospital-wide events) targeting all domains of leisure: physical, social, cognitive, emotional and spiritual, available 7 days/week, based on individual need/ability **Out-of-pocket costs to patient:** ALC co-payment for patients awaiting LTC placement	Therapy services available 7 days/week by Humber River staff: 0.5 FTE occupational therapist 1.5 FTE physiotherapists 1.0 FTE social worker 0.3 FTE speech language pathologist 0.5 FTE registered dietitian 0.5 FTE pharmacist 1.2 FTE recreational therapists Equipment: geri-chair, walkers (rollator, high-wheel) wheelchairs

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
Humber River Hospital Reactivation Care Centre	Humber River Hospital	34 beds – Humber Church site	Internal referrals only	Internal referrals only: • ALC status with confirmed discharge destination • Medically stable • Cleared by IPAC • Restorative potential • Dialysis only available at Church site • IV hydration and first dose Abx available Exclusion criteria: certain medical complexities (frequent transfusion, wounds > stage 3, ventilator, suction, bariatric, patient behaviours are risk to patient/staff injury, elopement risk, involuntary admission)	**Common patient group:** varied **Target LOS:** varied **Activities:** organized activities available 6 days/week **Common discharge destination:** varied **Layout:** hospital, dining room and activity room **Activities:** group and individual activities (including hospital-wide events) targeting all domains of leisure: physical, social, cognitive, emotional and spiritual, available 7 days/week, based on individual need/ability **Out-of-pocket costs to patient:** ALC co-payment for patients awaiting LTC placement	Therapy services available 6 days/week by Humber River staff: 0.6 FTE occupational therapist 1.6 FTE physiotherapists 1.0 FTE social worker 0.4 FTE speech language pathologist 0.5 FTE registered dietitian 0.5 FTE pharmacist 1.4 FTE recreational therapists Equipment: gerichair, walkers (rollator, high-wheel), wheelchairs

Mackenzie Health Reactivation Care Centre

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
Mackenzie Health Reactivation Care Centre	Mackenzie Health	56 beds[5] - Humber Finch site	Internal referrals only (call between patient coordinators) Dashboard on EPIC electronic patient system will be automated to support flow based on criteria[6] for RCC beds Exclusion criteria: bariatric (>300lbs), dialysis (HD and PD), outstanding consults (all need to be signed off), IPAC (airborne, CPE), short wait-time to LTC (i.e., <3 days to	Internal criteria (reactivation program only): • ALC status with confirmed discharge destination • Cases are reviewed by IPAC and family practice consult is completed to ensure suitability for transfer • Review is completed by PPC/Manager to ensure each unit has capability to manage the type of patients (i.e. behavioural needs)	**Common patient group:** varied **Target LOS:** varied **Common discharge destination:** LTC, retirement homes, home with community supports, group homes, palliative care units **Layout:** hospital, shared dining space/activity room on each floor and shared therapy gym on 4th floor only **Activities:** group activities with recreation therapist, rehab therapy, art therapy and complimentary therapy	Therapy services are shared between programs (MSK/CCC/reactivation) provided 7 days/week by Mackenzie Health staff. (Note: on weekends coverage is provided by 4 therapy assistants only): 2.0 FTE occupational therapists 2.0 FTE physiotherapists 4.0 FTE therapy assistants 1.0 FTE social worker 1.0 FTE speech language pathologist (shared with rehab programs) 1.0 FTE dietitian (shared with rehab programs) 1.5 FTE recreational therapists

[5] Humber Finch site also has additional 12 MSK rehab beds and 14 slow stream CCC beds, 10 long stay palliative CCC beds and 22 Complex Care CCC beds; these beds will be relocated back to Mackenzie Richmond Hill in spring 2021

[6] **Patient exclusion criteria include**: bariatric (>300lbs), dialysis (HD and PD), outstanding consults (all need to be signed off), IPAC (airborne, CPE), short wait-time to LTC (i.e., <3 days to placement), patient must be asymptomatic for greater than 72 hours (no fever, cough, nausea, vomiting, diarrhea), tracheostomy, discharge/destination not in place. Certain criteria require case by case reviewing.

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
Mackenzie Health Reactivation Care Centre (continued from previous page)	Mackenzie Health		placement), patient must be asymptomatic for greater than 72 hours (no fever, cough, nausea, vomiting, diarrhea), tracheostomy, discharge/destination not in place. Certain criteria require case by case reviewing.		(e.g., massage) **Out-of-pocket costs to patient:** ALC co-payment for patients awaiting LTC placement	2 FTE pharmacists (shared with rehab programs) Rehab offered in reactivation programs depends on individual's ability to participate. Other services include: patient care coordinators, complimentary therapists (0.5 FTE massage and art therapist)

Markham Stouffville Hospital Reactivation Care Centre

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
Markham Stouffville Hospital Reactivation Care Centre	Markham Stouffville Hospital	24 beds – Humber Finch site	Internal referrals only	Internal referrals only: • ALC status for at least 48h before transfer to RCC Exclusion criteria: certain medical complexities (e.g., bariatric, NG tubes, PICC lines, ongoing O2 titration, tracheostomies, elopement risk, significant responsive behaviours, requiring isolation (MRSA, C-diff, VRE).	**Common patient group:** varied, including frail seniors, patients admitted due to failure to cope, some hip fractures if can be reactivated, some stroke patients **Target LOS:** varied, depends on patient's reactivation goals **Activities:** organized activities available 7 days/week **Common discharge destination:** home with Bayshore/LHIN Home and Community Care supports, retirement home, external rehab facility, group homes, LTC. **Layout:** hospital with shared dining space, gym and activity room **Activities:** social/physical group activities available 1-2 times/day, in addition to one-to-one rehab, level of rehab depending on individual's need/ability. **Out-of-pocket costs to patient:** incontinence products, ALC co-payment for patients awaiting LTC placement	Therapy services available 6 days/week by Markham Stouffville staff: 0.6 FTE physiotherapist 0.4 FTE occupational therapist 1.4 FTE rehab assistants 1.4 FTE recreational therapists 1.0 FTE social worker 0.2 FTE pharmacist 0.4 FTE pharmacy technician 0.4 FTE registered dietitian 0.2 speech language pathologist Level of rehab depending on individual's need/ability, care plan developed by physiotherapist and occupational therapist on admission. Physiotherapy and occupational therapy sessions can vary between 20 min to 1 hour, depending on patient's tolerance. Equipment: rollator walkers, 2WW and 4WW walkers, high-wheeled walkers, wheelchairs, transfer board, mechanical lift, pivot disk, broada chair, SARA (Arjo) lift, saska poles

North York General Hospital Reactivation Care Centre

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
North York General Hospital Reactivation Care Centre	North York General Hospital	32 beds – Humber Finch site	Internal referrals only	Internal referrals only: • ALC status with approved discharge destination • Medical stability • Additional criteria for specific conditions (e.g., INR, drugs requiring therapeutic monitoring, CHF) Exclusion criteria: certain medical complexities (e.g., dialysis, bariatric, reactive or aggressive behaviours, wandering, stage IV wounds, palliative with prognosis of <3 months, need for ongoing consultations).	**Common patient group:** varied **Target LOS:** varied, 17-42 days **Activities:** organized activities available 7 days/week **Common discharge destination:** LTCH, convalescent care, rehab, home, retirement home, group home **Layout:** hospital, shared dining space, gym and activity room **Activities:** group activities available 2 times/day, level of rehab depending on individual's need/ability **Out-of-pocket costs to patient:** ALC co-payment for patients awaiting LTC placement	Therapy services available 6 days/week by North York General staff: 1.2 FTE physiotherapist (i.e., 1x 6 days/week) 0.8 FTE occupational therapist 1.4 FTE rehab assistant 1 FTE social worker 0.4 FTE pharmacist 0.4 FTE registered dietitian 0.4 FTE speech language pathologist 1.2 FTE recreational therapist Level of rehab depending on individual's need/ability. For example, physiotherapy is available one-to-one, 3 times/week, for a duration of less than 30 minutes (additional sessions provided by rehab assistant). Occupational therapy is available one-to-one, 3 times/week (additional sessions provided by rehab assistant). Equipment: walkers (high wheel/low wheel), stationary bike, hand bike

Southlake Regional Health Centre Reactivation Care Centre

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
Southlake Regional Health Centre Reactivation Care Centre	Southlake Regional Health Centre	30 – Humber Finch site 30 – Humber Church site	Internal referrals only	Internal referrals only: • ALC status Exclusion criteria: limitations related to certain medical complexities (e.g., limited number of PICC lines, some IV meds can be accommodated, unable to accommodate dialysis patients, no access to diagnostics, etc.)	**Common patient group:** varied, including frail seniors, MSK patients (hip/knees post-op) **Target LOS:** up to 90 days **Activities:** organized activities available 7 days/week **Common discharge destination:** home with services, retirement home, assisted living, LTCH. **Layout:** hospital layout - at Finch site shared dining space and activity room with another organization; at Church site gym and activity room are only used by Southlake's patients **Activities:** social/physical group activities available 2 times/day, in addition 1:1 rehab. Level of rehab depending on individual's need/ability. **Out-of-pocket costs to patient:** ALC co-payment for patients awaiting LTC placement	Therapy services available 7 days/week by Southlake staff (per site): 1.0 FTE physiotherapist 7 days/week 1.0 FTE rehab assistant 7 days/week 0.6 FTE occupational therapist 0.5 FTE registered dietitian 0.5 FTE speech language pathologist 1 FTE social worker 1 FTE recreational therapist 6 days/week 0.5 FTE pharmacist Level of rehab depending on individual's need/ability, care plan developed by PT and OT on admission following a consult. Rehab intervention is very individualized, ranging from 4 times/week to 1 time/week. Equipment: rollator walkers, wheelchair, transfer boards, exercise equipment such as stationary bicycle, weights, Therabands, etc.

Sunnybrook Health Sciences Centre Reactivation Care Centre

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
Sunnybrook Health Sciences Centre Reactivation Care Centre	Sunnybrook Health Sciences Centre	60 beds – at Humber Church site	Internal referrals only	Internal referrals only: • ALC status Exclusion criteria: certain medical complexities (bariatric, VAC, BiPAP, deep suctioning, ceiling lifts, chest tubes, NG tube feeds, TPN, tracheostomies, access to diagnostics, dialysis with pre-approval only).	**Common patient group:** patients awaiting LTC placement, patients requiring few more weeks of antibiotics, patients requiring reactivation before they are discharged home with services **Target LOS:** 60 days **Activities:** organized activities available 7 days/week **Common discharge destination:** LTC **Layout:** hospital layout with two units (one unit with 32 beds, another with 28 beds) **Activities:** social/physical group activities available 2 times/day, in addition 1:1 rehab. Level of rehab depending on individual's need/ability. **Out-of-pocket costs to patient:** Transportation, ALC co-payment for patients awaiting LTC placement	Therapy services available 7 days/week by Sunnybrook staff: 1.0 FTE physiotherapist 1.0 FTE occupational therapist 2.0 FTE rehab assistants 2.0 FTE recreational therapists 2.0 FTE social worker 1.0 FTE registered dietitian 0.8 dietary technician 1.0 pharmacist 1.0 pharmacy technician 1 time/week chaplain 1 time/week music therapists Level of rehab depending on individual's need/ability, care plan developed by the interprofessional team at the beginning of the month. Rehab intervention is individualized, ranging from 1 to 5 times/week. Equipment: large storage area with geri chairs, wheelchairs, rollator walkers, etc.

St. Joseph's Health Centre Reactivation Care Centre

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
St. Joseph's Health Centre Reactivation Care Centre	St. Joseph's Health Centre/Unity Health Toronto	30 beds – at Humber Church site	Internal referrals only	Internal referrals only: ALC status	**Common patient group:** MSK patients post fracture with non-weight-bearing status **Target LOS:** 21-28 weeks **Activities:** organized activities available 7 days/week **Common discharge destination:** home with services and rehab **Layout:** hospital layout with dining room and patient lounge **Activities:** social/physical group activities available 2 times/day. Level of rehab depends on individual's need/ability. **Out-of-pocket costs to patient:** ALC co-payment for patients awaiting LTC placement	Therapy services available 7 days/week by St. Joseph's staff (per site): 1.5 FTE physiotherapist 1.0 FTE occupational therapist 1.5 FTE rehab assistant 1.5 FTE recreational therapist 0.5 FTE registered dietitian 0.5 FTE speech language pathologist 1 FTE transition planner Level of rehab depending on individual's need/ability, care plan developed by therapy team. Rehab intervention is very individualized. Besides organized activities, nurses bring patients to the hallways to practice walking. Equipment: rollator walkers, two-wheel-walkers, commodes, wheelchairs, broad chairs, hoyer lifts, commodes, hand bikes, gym equipment

Trillium Health Partners Reactivation Care Centre

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
Trillium Health Partners Reactivation Care Centre	Trillium Health Partners	69 beds – Humber River Church site	Internal referrals only	Internal referrals only, cases reviewed individually for eligibility.	**Common patient group:** MSK patients post fracture with non-weight-bearing status, patients awaiting LTC, patients with cognitive impairment/challenging behaviours that require a locked unit **Target LOS:** 4-18 weeks **Activities:** organized activities available 7 days/week **Common discharge destination:** LTC, rehab **Layout:** hospital layout, dining room and shared gym **Activities:** social/physical group activities available 2 times/day. Level of rehab depends on individual's need/ability. **Out-of-pocket costs to patient:** ALC co-payment for patients awaiting LTC placement	Therapy services available 7 days/week by Trillium staff: 1.5 FTE physiotherapist 1.5 FTE occupational therapist 2.1 FTE recreational therapist 1.0 FTE registered dietitian 0.7 FTE speech language pathologist 1.0 FTE social worker 0.6 FTE pharmacist Level of rehab depending on individual's need/ability, care plan developed by therapy team. Patients awaiting LTC are on a maintenance program, while patients awaiting rehab are provided with more rehab interventions depending on their goals and abilities (e.g., 3-5 times/week with a therapist and PTA/OTA). Equipment: rollator walkers, two-wheel-walkers, commodes, wheelchairs, broad chairs, hoyer lifts, commodes, hand bikes, gym equipment, therabands, ceiling lifts.

Community Programs (pages 21-25)

Carefirst Transitional Care Model

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
Carefirst Transitional Care Program	Scarborough Health Network	20 beds *Note: Reduced bed capacity from 29 to 20 beds following COVID-19 pandemic*	Internal referrals: internal discussions with Scarborough Health Network External referrals: program can be accessed by other hospitals at a per diem cost to patient. Click here for more information on external referrals.	• Patients/clients who are motivated to participate, have rehab potential, and require assistance with ADLs (1- assist, or 2-assist if there is potential to progress) • Must be cleared by IPAC • Able to take clients who wander with manageable behaviours	**Common patient group:** seniors with medical frailty and dementia, adults with chronic conditions (CHF, COPD, diabetes) **Target LOS:** 21 days **Common discharge destination:** home/community **Layout:** retirement home with congregate dining space **Activities:** social programming and group activities similar to the convalescent care/retirement home programs **Out-of-pocket costs to patient**: similar costs to living in the community (e.g., medication, incontinence products)	Care provision by CareFirst and Scarborough Health Network staff (through Assess and Restore funding): 1 FTE physiotherapist 0.5 FTE physiotherapy assistant 1 FTE social worker If involvement of other allied health is needed, they are contracted through LHIN Home and Community Care. Level of 1:1 rehab required depends on individual assessment. Equipment: walkers, canes, commode. Additional programs: diabetes educational program, CBT for caregivers (delivered by Ontario Shores), primary care doctors visiting the unit

Hillcrest Reactivation Care Centre

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
Hillcrest Reactivation Care Centre	University Health Network	66 beds *Note: Reduced bed capacity from 75 to 66 beds following COVID-19 pandemic*	Referrals restricted to patients from all Toronto Region hospitals (acute care and rehab/CCC). All referrals are electronic and made utilizing Central Referral Management System operated by Bellwoods	Eligibility criteria for more complex patient groups may vary depending on current case mix on the unit (examples of complex patient groups: 2-assist, hoyer-lift transfer, complex wounds VAC). Exclusion criteria: active exit-seeker, active suicidal risk, responsive aggressive behaviors	**Common patient groups:** seniors with medical complexity /frailty, adults with dementia and/or mental health issues **Target LOS:** 42-60 days **Common discharge destination:** home/community with services **Layout:** hospital layout with congregate dining space and wander-guard unit (note: availability of wander guard unit may be impacted by COVID-19 pandemic) **Activities:** reactivation programming throughout the day including physical (yoga, Zumba, seated-exercises), social/cognitive programing (kitchen activities, crafts) **Out-of-pocket costs to patient:** similar costs to living in the community (e.g., medication, incontinence products)	Client care provided by SE Health. Available allied health staff include: physiotherapist, occupational therapist, physiotherapy assistant, social worker, recreation therapist / therapy assistants. Level of 1:1 therapy provided based on assessment and client goals.

Lakeridge Health Transitional Care Model

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
Lakeridge Health Transitional Care Models	Lakeridge Health	100 beds across different retirement homes - Carriage House (34 beds), Traditions of Durham (26 beds), Orchard Villa (10 beds), Abbeylawn (14 beds).	Internal referrals only – through EMR	Internal criteria	**Common patient group:** seniors with medical frailty and dementia (no responsive behaviours) **Target LOS:** None, based on patient need **Common discharge destination:** LTC **Layout:** retirement residence **Activities:** social programming and group activities similar to the convalescent care/retirement home program. **Out-of-pocket costs to patient**: daily co-payment (based on financial assessment)	Services provided by Bayshore: 2.0 FTE physiotherapist 1.0 FTE occupational therapist 3.0 FTE rehab assistant Level of rehab depends on individual's need/ability. Rehab is provided approximately 15-30 minutes per day, 3-5 times/week for one-to-one interventions, and group therapy 5 times per week for 30 minutes (note: group therapy is on hold due to the COVID-19 pandemic).

North York General Hospital Transitional Care Rehab Unit

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
North York General Hospital Transitional Care Rehab Unit	North York General Hospital	20 beds – Queen's Estate Retirement Home	Internal referrals only (from inpatient units and from ED)	Internal referrals only Exclusion criteria: certain medical complexities (bariatric, isolation requirements (except MRSA).	**Common patient group:** varied **Target LOS:** up to 60 days **Common discharge destination:** home with community services or retirement home **Layout:** retirement home **Activities:** therapy is available 5 days/week (2 times/day for group activities, 1 time/ day for 0.5h physiotherapy session). Duration is based on physical tolerance and individual goals. Rehab activities include: teaching correct transfer techniques, LE strengthening with peddler, 1:1 strength exercises with weights/TheraBand, 1:1 standing balance exercises and high balance exercises, 1:1 bed exercises, seated exercises for strength coordination and endurance, 1:1 gait training and walking program, and teaching how to use aides to support ADLs. **Out-of-pocket costs to patient:** None	Therapy services available 5 days/week by Bayshore staff: 1 FTE physiotherapist 0.2 FTE occupational therapist 3 FTE rehab assistants 0.2 FTE social worker 0.1 FTE registered dietitian Equipment: exercise equipment (peddler for extremity strengthening, weights, TheraBand with varied resistance, shoulder pulleys and hand exercisers)

St. Hilda's Senior Care Community Reactivation Care Centre

Short Term Transitional Care Model	Organization	Number and Types of Spaces	Referral Process	Eligibility Criteria	Description	Rehabilitative Care Services
St. Hilda's Senior Care Community Reactivation Care Centre	University Health Network	9 beds	Referrals restricted to patients from all Toronto Region hospitals (acute care and rehab/CCC). All referrals are electronic and made utilizing Central Referral Management System operated by Bellwoods.	Eligibility criteria for more complex patient groups may vary depending on current case mix on the unit (examples of complex patient groups: 2-assist, hoyer-lift transfer, wound VAC). Exclusion criteria: active exit-seeker, active suicidal risk.	**Common patient group:** seniors with medical frailty **Target LOS:** 42 days **Common discharge destination:** home/community with services **Layout:** retirement residence, congregate dining space **Activities:** social programming and group activities similar to the convalescent care programs **Out-of-pocket costs to patient:** similar costs to living in the community (e.g., medication, incontinence products)	Care provision by St. Hilda's staff including personal support workers and registered practical nurses: 1.0 FTE nurse practitioner 1.0 FTE physiotherapist Level of 1:1 therapy provided based on assessment and client goals.

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