

**TORONTO CENTRAL LHIN / GTA REHAB  
NETWORK PROJECT CHARTER:  
ENHANCING ACCESS AND PATIENT FLOW FOR  
REHAB AND CCC  
TO SUPPORT ER/ALC PRIORITIES**

**FINAL REPORT**

**APRIL 2010**

**Submitted by:**  
GTA REHAB NETWORK

**Submitted to:**  
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## 1.0 INTRODUCTION

The GTA Rehab Network has engaged in a variety of initiatives to support access and patient flow for rehab and complex continuing care (CCC). In 2009, the Network entered into an agreement with the Toronto Central LHIN to further identify and address issues related to enhancing patient flow for rehab and CCC. The Toronto Central LHIN provided funding for the following four GTA Rehab Network project charters:

- Enhancing Access and Patient Flow for Rehab and CCC to Support ER/ALC Priorities
- Rehab Definitions
- Resource Matching and Referral Support
- Evaluation of the LIFEsplan Transition Model

This report is specific to the project charter, Enhancing Access and Patient Flow for Rehab and CCC to Support ER/ALC Priorities. The project's completion date is March 31, 2010. Final reports on the other project charters have been submitted separately.

The Network's primary focus for the charter has been to build on previous work and to conduct an analysis of the referral data gleaned from the electronic Resource Matching and Referral System (RM&R). Through monitoring of the monthly reports provided by RM&R, the analysis has been used to identify operational system issues affecting patient flow to support ER/ALC priorities. The Network's Patient Access and Flow Committee<sup>1</sup> has been instrumental in supporting the Network to achieve the deliverables of the project.

This report provides a summary of the Network's patient flow recommendations that have been obtained through an analysis of the data available through RM&R. The monthly data reports provide an overview of aggregated findings across program types (i.e. HTSD, LTLTD and CCC) and/or across LHINs based on client postal code. Although the monthly report is intended to provide organization-specific information, details regarding the data sharing agreements with organizations participating in the RM&R system had not been finalized and as a result organization-specific data was not shared publicly.

At the time of the project charters completion (March 31, 2010), the extent of analysis has been somewhat limited due to the following factors.

1. There were delays in accessing data from RM&R. As a result of the Network's initial monitoring of the data, several recommendations were made to improve the quality of the data captured. A number of upgrades and data quality checks were made, which in turn required SIMS to redo the initial reports for May, June and July. The Network received the first revised report, which reflected August referral data, on October 16<sup>th</sup>, 2009. Revised reports for May, June and July have not been provided.
2. Following the October update to the reporting template, other technical and process issues affecting the quality of the data were identified. These are discussed in detail in subsequent sections.

While there continue to be challenges in transitioning more complex patients/referrals to rehab and CCC within the Toronto Central (TC) LHIN, the introduction of the Resource Matching and Referral system provides useful information to help identify referral and patient flow patterns and areas for improvement. It has also contributed referral process efficiencies for both sending and receiving organizations. Recognizing that the RM&R system is in a relatively early stage in its evolution as a large-scale electronic application, the recommendations that are put forth in this report are done so in the spirit of enhancing the quality of the data captured and the system's capacity to provide meaningful information on patient flow to inform ongoing system-wide improvements.

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<sup>1</sup> The Patient Access and Flow Committee was established in the fall of 2006 as part of the Network's strategic focus on improving service delivery and access and to help members of the GTA Rehab Network work towards the goal of decreasing Alternate Level of Care (ALC) days. Members of the committee represent the following organizations: Baycrest, Bridgepoint Health, Providence Healthcare, St. John's Rehab Hospital, Toronto Rehab, West Park Healthcare Centre, Mount Sinai Hospital, St. Michael's Hospital, Sunnybrook Health Sciences Centre, University Health Network, St. Joseph's Health Centre, Toronto East General Hospital, Toronto Grace Health Centre, Runnymede Healthcare Centre, UHN/Shared Information Management Services and the Toronto Central CCAC.

## 2.0 PROJECT DESCRIPTION AND PROJECT DELIVERABLES

In its effort to support the ER/ALC priorities to enhance access and patient flow to inpatient rehab and CCC, the GTA Rehab Network was funded to review, monitor and analyze the monthly referral data available through RM&R. More specifically, the goals of this review and analysis have been to:

- understand and address factors contributing to delays in patient flow
- inform improvements in RM&R data collection and reporting
- identify opportunities for program-system changes to enhance patient flow
- identify and develop patient flow support tools for health service providers
- provide recommendations to the TC LHIN regarding processes, policies and other issues that may need to be addressed to enhance patient flow through inpatient rehab and complex continuing care

There are three broad deliverables associated with the project:

1. Implementation of an approach to manage the ongoing review of RM&R
2. Implementation of Patient Flow Support Tools for Health Service Providers
3. Submission of patient flow recommendations to the Toronto Central LHIN

The progress made to date on each of the deliverables is discussed in Section 3.0.

**3.0 DELIVERABLES**

**3.1 DELIVERABLE: Implementation of an Approach to Manage the Ongoing Review of RM&R**

Step One: Review and provide recommendations for RM&R reporting template

The key objectives of reviewing and analyzing the RM&R data reports were to provide information to facilitate gap analysis, system planning, and evidence-based decision-making as it relates to enhancing patient flow. The Network’s first step (spring 2009) towards the achievement of this deliverable was to review the initial reporting template developed by Shared Information Management Services (SIMS) and to make recommendations to improve the quality and relevance of the data captured. The presentation of the RM&R data in the initial reports limited the use of the data for pinpointing referral inefficiencies and understanding demand and capacity as well as barriers to patient flow. The Network used the following questions (See Table 1) related to patient flow to help guide its recommendations for improving the parameters used in the data reports. (See Appendix A for additional information on the Network’s recommendations.) Although not all recommendations have been implemented, the GTA Rehab Network acknowledges that the recommendations are being considered within the overall program development of the RM&R system as well as within the availability of human and economic resources.

**Table 1**

<u>PATIENT CHARACTERISTICS</u>
<b>1. What are the characteristics of patients referred to rehab and CCC; how many are being referred; and to which programs are they being referred?</b>
<p><b><u>GTA RN Recommendation:</u></b></p> <ul style="list-style-type: none"> <li>▪ Include referral data by population type (e.g. MSK, Cardiac etc.), gender and age categories in addition to tracking the number of referrals submitted by and to organizations.</li> </ul> <p><b><u>Rationale:</u></b> This additional information increases our understanding of where the demand for services is highest and lowest, a key element when considering questions related to capacity and gaps in services.</p> <p><b><u>Status:</u></b> × Partially implemented</p> <ul style="list-style-type: none"> <li>✓ Referrals by sending and receiving organizations implemented (but not publicly shared as yet)</li> <li>× Referral data by population type partially implemented. Referral data is categorized into some of the population groups for some of the data tables. The categorization is based on the current listings of programs in the RM&amp;R system, which does not accurately reflect the rehab/CCC options available. In addition, there are several population groups that are excluded entirely from the RM&amp;R system. (See next section, <i>Step Two: Identify Data Limitations</i>) The GTA Rehab Network has offered its assistance to SIMS to identify a more comprehensive list of population groups to better facilitate referral processes and reporting capabilities.</li> <li>× Referral data by gender and age categories not implemented</li> </ul>

**REFERRAL INEFFICIENCIES AS MEASURED AGAINST BENCHMARKS****1. How quickly are referrals responded to?****GTA RN Recommendation:**

- Include referral data by response time categories (e.g. number of referrals with response < 2 days, 3-5 days etc.), average response time, program type, population type and receiving organization.

**Rationale:**

The specificity of this data helps to pinpoint which rehab/CCC programs are not meeting the response time benchmark established by the GTA Rehab Network.

**Status:** ✘ Partially implemented

- ✔ Average response time by program type implemented
- ✔ Response time by organization is available but not publicly shared yet
- ✘ Response time categories (e.g. < 2 days, 3-5 days) not implemented
- ✘ Average response time by population partially implemented. Not all population types have been incorporated into the report. The GTA Rehab Network is working with SIMS to identify a more comprehensive list of population groups to better facilitate referral processes and reporting capabilities.

**GTA RN Recommendation:**

- Include referrals that were submitted outside of the reporting period.

**Rationale:**

The initial RM&R reports only included referrals submitted and responded to within the monthly reporting period. As a result, referrals that were waiting for a response from an earlier month were not reflected in the data. Including these referrals ensures that lengthy response times are included in the data capture.

**Status:** ✔ Implemented

**2. For how many referrals are responses pending and how long have they been pending?****GTA RN Recommendation:**

- Include a "Send Back" function to enable tracking of referrals that have been responded to by the receiving organization, but are "pending" because additional information is required.

**Rationale:**

The GTA Rehab Network's Inpatient Rehab/LTLD Referral Guidelines stipulates that a request for additional information or clarification of referral information constitutes a response by the receiving organization. Initially, RM&R only provided an "Accept" or "Deny" function. However, the referral process often includes communication between the sending and receiving facility in the interim. The time involved in this process should be captured and monitored.

**Status:** ✔ Implemented

**PATIENT FLOW AND CAPACITY**

**1. How many referrals/patients have been accepted for rehab but are waiting? Why are they waiting? Which programs are they waiting for? What is the average and median wait time by population?**

**GTA RN Recommendation:**

- Include data for each program type and population.

**Rationale:**

Initially, referrals accepted and waiting and associated waiting times were reported by special care needs. However, in the absence of knowing the reason for waiting, no direct link can be made between waiting time and special needs. Providing waiting times by program type and population increases our understanding of where delays in patient flow are occurring.

**Status:** ✗ Partially implemented

- ✓ Accepted and waiting by program type implemented
- ✗ Accepted and waiting by population partially implemented. Not all population types have been incorporated into the report. A more comprehensive list of populations is needed to accurately reflect the rehab/CCC programs that are available.

**GTA RN Recommendation:**

- Include reasons for waiting.

**Rationale:**

This information can be used to help target where *additional* capacity may be needed. For example, are lengthy wait times owing to a program's lack of capacity to meet a special need? Is the wait time because of infection control needs of the patient on the rehab unit? Information on why referrals are waitlisted can be used to determine which programs (e.g. HTSD vs. LTLTD vs. CCC) and what type of additional resources are needed to increase timely access to rehab/CCC and improve patient flow. Providing population-specific information (e.g. MSK, Neuro, and Spinal Cord Injury etc.) further helps to pinpoint where additional resources and/or efficiencies may be directed.

**Status:** ✗ Not implemented

**GTA RN Recommendation:**

- Track wait times by population
- Track median wait times

**Rationale:**

The tracking of wait time by population enables a deeper understanding of where bottlenecks occur. Reporting median wait time provides added information that is often not apparent when only average wait times are used (i.e. average times may be skewed by outliers)

**Status:** ✓ Implemented

While median wait times are not reported, the range of wait times is provided by population and program type.



**PATIENT FLOW AND CAPACITY**

**1. How many referrals/patients have been accepted for rehab but are waiting? Why are they waiting? Which programs are they waiting for? What is the average and median wait time by population?**

**GTA RN Recommendation:**

- Revise the start time for tracking wait time from the date patient is rehab ready to the date that the referral is sent.

**Rationale:**

There are inconsistencies in how rehab readiness is understood, determined and applied by acute care and rehab facilities when a rehab application is submitted and reviewed.<sup>2</sup> Inconsistencies in determining rehab readiness among the health professionals within each of these types of facilities can also exist. There is no clear, reliable, quantitative measure for determining rehab readiness that would eliminate inconsistencies in determining rehab readiness. The date the referral is sent provides a clear and concrete marker that would be applied consistently by both acute care and rehab facilities. As such, it would be a more appropriate and consistent starting point for tracking wait time.

**Status:** ✗ Not implemented

**2. How many clients have all of their referrals denied and for these clients, where were they referred (e.g. type of program and population) and what are the reasons for denial?**

**GTA RN Recommendation:**

- Include a comprehensive list of reasons for denials. Identify number of referrals and clients for whom all referrals were denied by program type, population type and organization.

**Rationale:**

This information can be used to help target where *new* capacity is needed to accommodate the needs of the patients who are not accepted by some or any program.

**Status:** ✗ Partially implemented.

- ✓ Reasons for denial implemented
- ✓ Reasons for denial by program type implemented
- ✗ Reasons for denials by population and organization not implemented
- ✗ Number of clients with all referrals denied partially implemented. Only the number of clients with special needs whose referrals have all been denied are reported by program type.

<sup>2</sup> The GTA Rehab Network's Inpatient Rehab/LTLD Referral Guidelines provide seven criteria for determining rehab readiness; however, how these criteria are applied to patients may vary among healthcare professionals in acute care and rehab facilities.

**Step Two: Identify Data Limitations**

The following data limitations restrict our ability to fully identify referral inefficiencies; understand demand, capacity and barriers to patient flow; and identify opportunities for program/system changes to enhance patient flow.

1. Subsequent to the release of the December report, a problem with the functionality of the system was identified such that the extraneous referrals of admitted clients (i.e. referrals no longer needed) were not automatically cancelled by the system, as was assumed. This resulted in inflated numbers for referrals accepted and waiting; pending referrals and the waiting time categories associated with these referrals. This also affected the total counts of the special needs associated with referrals accepted and waiting and pending. This issue was to be corrected in February.

**Note:** Corrections are generally implemented on a “go forward” basis and as such, data that was reported before these correction points were not updated. It is important to take this into consideration when reviewing data across several months for the purpose of identifying trends.

2. In January, the GTA Rehab Network learned that the RM&R system had been including some admitted referrals in the calculation of the number of referrals accepted and waiting, as reported in Chart 2.5. This was corrected for the January report.
3. The number of “*accepted and waiting*” referrals may also be inflated due to the current process for cancelling referrals. Acute care does not have the resources, given its high patient turnover rate, to track the ultimate discharge destinations of patients sent to a community hospital to await admission to rehab/CCC. If the patient does not end up going to rehab/CCC, it is incumbent on acute care to cancel the referral in the RM&R system. This is typically not done, thereby inflating the number of referrals in the RM&R system that are tagged as “*accepted and waiting*.” This feedback was communicated to the SIMS reporting team to inform enhancements to the functionality of the RM&R system.
4. Information on referral volumes (as well as other data points) does not include the following rehab populations: ABI referrals; E-Stroke referrals; pre-booked referrals (e.g. MSK referrals); referrals to Geriatric Psychiatry, referrals to Palliative Care by acute care and referrals made by organizations outside of the TC LHIN (i.e. those not using RMR). In addition, the extent to which the RM&R system is used for referrals where organizational relationships exist between acute care and Rehab/CCC hospitals is not known. Furthermore, referrals to CCC at Sunnybrook Health Sciences Centre (for veterans only) and to Toronto East General Hospital are currently not made through the RM&R system, although other types of referrals from these two organizations are captured by the RM&R system.

As a result of these exclusions, data from the RM&R system does not reflect the full picture of demand on the rehab/CCC system, both in terms of its capacity to accommodate the needs of patients and support patient flow (i.e. providing patients with the right rehab/CCC services) as well as its capacity to respond quickly and efficiently to *all* referrals (i.e. how well referral process benchmarks are met for paper-based referrals).

5. The program matching criteria within RM&R needs improvement as the current criteria do not accurately reflect the rehab/CCC program options that are available. A recent audit of the use of the override function<sup>3</sup> by referrers showed that from April 2009 – February 2010, overrides were used on average for 30% of the referrals (Range: 26 – 33%).
6. The report, at this time, does not directly link the number of referrals that are waitlisted to specific reasons for waitlisting. This information would help to determine where additional capacity is needed.

**Step Three: Propose an approach for ongoing monitoring of the RM&R System**

The Network’s detailed review of the monthly data report plays a pivotal role in the monitoring of the RM&R system. As part of this review, the Network has conducted detailed analyses of the monthly reports drawing on its clinical expertise and experience to identify inconsistencies and irregularities in the

<sup>3</sup> The override function is used by a referrer when she/he wants to send the referral to a program that is different from the one(s) identified by the RM&R system.

data fields used and in the data findings themselves. Summaries of the Network's analyses of the monthly reports have been reviewed and discussed at the Network's Patient Access and Flow Committee where questions regarding the data findings were brought forward for input from those directly involved in the referral process at both acute care and rehab/CCC hospitals.

The GTA Rehab Network, with its system-wide focus and its ability to provide a "clinical filter" for the analysis of the monthly data report based on its detailed knowledge and practical experience with the referral process, is ideally situated to:

- review the data analysis, identify inconsistencies within the data and determine which findings make sense and which do not
- identify technical and process issues in the RM&R system that affect how data is captured
- provide oversight to ensure proper utilization of RM&R system

For example, the Network has identified the following issues affecting the use and quality of the data captured.

- ▶ Cancellation of referrals by acute care is often not done (See Step Two, No. 3 above)
- ▶ The RM&R system is very slow for reviewing and responding to referrals, which is contributing to referrers bypassing the system to process referrals via telephone consultation instead. As a result, the Send Back function is bypassed for obtaining updates and the response loop is not closed through RM&R. In addition, the Redirect function is often bypassed as well. This has been highlighted in the Network's monthly reports as limitation of the data that is captured and the need for functional enhancements to RM&R.
- ▶ The Network has also reported that programs do not always register a patient in RM&R when he/she is admitted to their organization. As a result, the number of patients admitted may be inaccurately reported and the wait times may be artificially inflated. The Network has recommended that regular audits (e.g. bi-annually) be conducted by RM&R to ensure that all individuals, new and seasoned users, are using the system correctly.

These examples illustrate that the GTA Rehab Network has played an important role in reviewing the data that is captured from an analytical *and* clinical perspective, highlighting discrepancies in the data and using the information to identify system improvements to support patient flow and the ER/ALC priorities across the system. Without the Network's system-wide focus, each organization would examine and respond to the results from its own organizational perspective and the systems-wide perspective would be ignored.

### **3.2 DELIVERABLE: Implementation of Patient Flow Support Tools for Health Service Providers**

The GTA Rehab Network has developed a number of new resources for service providers to support patient flow.

- i. Decision tree to support referral process for patients who are re-admitted to acute care  
The decision tree clarifies the information and processes required when patients are re-admitted to rehab or CCC following a transfer to acute care. It takes into consideration the patient's medical stability, the level of change that has occurred in the patient's functional status and the processes required to ensure that the appropriate information is sent to the rehab/ CCC program. The decision tree was implemented into the RM&R system in March 2009.
- ii. Quick reference tool for acute care referrers  
The Quick Reference Referral Guide to Inpatient Rehab, Complex Continuing Care and Palliative Care Programs in the GTA<sup>4</sup> has been designed as an adjunct to Rehab Finder as a printable, easy to read overview of programs for referrers, families and clients. The program listings within this tool have been reviewed as a basis for updating the program options within RM&R and in how these options are reported in the monthly data reports.

<sup>4</sup> Available at <http://www.gtarehabnetwork.ca/QuickReferenceReferralGuide.asp>.

The Network is working with its database developer to link the quick reference guide with our existing processes for updating records within Rehab Finder's searchable database.

iii. Discharge planning principles and guidelines for rehab/LTLD

The Discharge Planning Guidelines for Inpatient Rehabilitation<sup>5</sup>, disseminated in April 2009, promote leading practices in discharge planning and facilitate timely discharge from inpatient rehab. They build on the Network's recent work on Alternate Level of Care (ALC) in inpatient rehabilitation/CCC and its work on the provincial ALC Definition Working Group. The guidelines set out guiding principles, standards and discharge readiness criteria for inpatient high tolerance and low tolerance rehab programs and support early initiation of discharge planning to enhance patient flow. They also incorporate the Provincial ALC Definition that was implemented across all acute and post-acute hospitals on July 1, 2009 and supplement the provincial ALC toolkit.

The Network evaluated the uptake and impact of the guidelines in November, 2009 and found that they are providing valuable support. The majority of HTSD rehab programs (86 per cent) and LTLD programs (78 per cent) found the guidelines helpful in:

- ▶ increasing clarity and consistency in the discharge planning process;
- ▶ facilitating team communication around discharge planning practice;
- ▶ validating and reinforcing existing processes; and
- ▶ facilitating the development of a model of care for rehab.

Sixty-five per cent of programs have formally implemented the guidelines. Of those remaining, half reported that their current discharge practices align with the guidelines. Several programs will implement the guidelines in the near future. (A full summary of the evaluation is available at <http://www.gtarehabnetwork.ca/downloads/report-discharge-planning-guidelines-jan2010.pdf>.) All inpatient rehab/LTLD programs have been encouraged to incorporate the guidelines into clinical team practices.

Inpatient Rehab/LTLD Rehab Referral Guidelines updated<sup>6</sup>

In addition to providing new guidelines for transitioning patients *from* inpatient rehabilitation, the Network updated its inpatient rehab/LTLD rehab referral guidelines (May 2009). These guidelines support the transition of patients *into* inpatient high tolerance and low tolerance long duration rehabilitation. The referral guidelines standardize the rehab referral process and provide criteria to help determine when a patient is: a candidate for inpatient rehab; medically stable; rehab ready and appropriate for the ALC designation according to the new provincial definition.

iv. Standard bed holding policy for rehab and CCC

The need for a common bed holding policy was identified through the SIMS Rounds in winter 2009 and supported by the CEOs of the SIMS partner organizations. A draft bed holding policy for rehab and CCC was developed to support consistency in timelines and processes in the repatriation of patients to rehab and CCC hospitals following an admission to acute care. The draft policy was submitted to SIMS CIO for review on March 27, 2009.

The bed holding policy defines the maximum length of time a bed may be held in a rehab/CCC hospital in anticipation of the return of the patient from acute care. The policy is designed to optimize patient flow, ensure continuity of care for patients, maximize bed utilization in both acute care and rehab/CCC, and support consistent timelines and repatriation processes across all hospitals.<sup>7</sup>

The draft policy was subsequently piloted from April 20 – June 30, 2009 in the freestanding rehab/CCC hospitals<sup>8</sup> and Toronto East General Hospital. Organizations that had already implemented a “no bed holding” policy within some or all of their programs served as controls for the pilot. A tracking tool was developed for consistency in the collection of data to determine the impact of bed holding on occupancy and patient flow.

<sup>5</sup> Available at <http://www.gtarehabnetwork.ca/DischargePlanningGuidelines.asp>.

<sup>6</sup> Available at [http://www.gtarehabnetwork.ca/referral\\_guide.asp](http://www.gtarehabnetwork.ca/referral_guide.asp).

<sup>7</sup> Available at <http://www.gtarehabnetwork.ca/BedHoldingPolicy.asp>.

<sup>8</sup> Baycrest, Bridgepoint Health, Providence Healthcare, St. John's Rehab Hospital, Toronto Rehab, West Park Healthcare Centre, Runnymede Healthcare Centre and Toronto Grace Health Centre.

The GTA Rehab Network analyzed and reported on 10 weeks of data (April 20-June 30) for 192 patients who were returned to acute care from rehab/CCC hospitals. The results of the pilot were presented and discussed at the Network's Forum on Flow on July 22<sup>nd</sup> attended by over 70 participants. Findings from the pilot included:

- Readmission was faster when beds were held:
  - When beds were held, patients were re-admitted on average within 0.6 days of readiness to return.
  - When beds were not held, patients were re-admitted on average within 4 days.
- Length of stay in acute was twice as long for patients when the bed was not held
  - Average of 7 days when bed was held versus 16 days when bed was not held
- Patients were readmitted to the same program at a higher rate when beds were held
  - 97% of patients were readmitted to same program when bed was held versus 83% when bed was not held.
- Proposed timelines in policy would capture the majority of patients when they were ready to return
  - 94% of patients in CCC were ready to return within the proposed 14 day timeline
  - 66% of patients in LTLTD were ready to return within the proposed 7 day timeline

All organizations/programs that participated in the bed holding pilot by holding beds for patients who were sent back to acute care continued to use the bed holding policy following the end of the pilot. They reported that they found the timelines within the policy to be very helpful in helping to manage the repatriation of their patients from acute care. In October, the Network sought additional feedback from representatives in acute teaching hospitals on the draft policy. All supported it as fair and appropriate.

In September, the Network met with Professor Michael Carter (University of Toronto, Dept. of Mechanical and Industrial Engineering) to explore the feasibility of conducting a simulation study to provide "real time" patient flow information on patients waiting in acute care for a CCC bed (i.e. both newly referred patients and those waiting to be repatriated). The range of costs for conducting a simulation model through Professor Carter is \$5,000-\$25,000 which was deemed outside the budget and of questionable value given the support for the current policy.

Given the widespread support for the bed holding policy, the VPs of the rehab/CCC hospitals approved the policy for implementation in the freestanding rehab/CCC hospitals in the GTA. In addition, each of the CEOs of the adult freestanding rehab/CCC hospitals provided written endorsement of the new policy in January 2010 and the new policy was implemented across these hospitals on February 1, 2010. The Network has developed a template for use by the rehab/CCC hospitals to monitor the impact of implementing the bed holding policy. Information will be tracked for the period from April 1, 2010 to June 30, 2010.

v. *Rehab/CCC Referral Teleconferences and Forum*  
 Fall 2008/Winter 2009

In fall 2008, the GTA Rehab Network was asked by the SIMS Partnership organizations to chair weekly teleconferences with stakeholders from acute care, inpatient rehab and CCC. Ten teleconferences were held from November 2008 to January 2009. The overall objective of the weekly calls was to provide some immediate ALC relief by better targeting referrals to available inpatient rehab and CCC beds within the Toronto Central (TC) LHIN. Real time information was obtained on the availability of designated rehab beds, LTLTD beds and general CCC beds across Toronto Rehab, West Park Healthcare Centre, Bridgepoint Health, Providence Healthcare, St. John's Rehab Hospital, Baycrest, Toronto Grace Health Centre and Runnymede Healthcare Centre.

Participants reported the teleconferences were helpful for:

- Increasing referrers' knowledge of rehab/CCC programs, including admission and exclusion criteria
- Identifying potential referral options in rehab/CCC for patients with complex needs
- Providing education about strategies and clinical practices to optimize patient care/management for patients in acute care awaiting transfer to rehab/CCC or for those in rehab/CCC programs

Participants found the teleconferences to be helpful in supporting communication and collaboration among referrers and rehab/CCC referral receivers as well as in increasing knowledge about rehab/CCC programs. However, participants found the weekly teleconferences to be labour intensive (i.e. Rehab/CCC organizations reported the number of beds available for each program at each teleconference). In addition, the data that was tracked each week with regard to bed availability were limited as the data did not reflect the referrals already in progress at the time of the call.

#### Summer 2009

On July 22, 2009, the GTA Rehab Network convened a half-day Forum on Flow. The forum, attended by over 70 healthcare professionals<sup>9</sup> from acute care and rehab/CCC hospitals, CCACs and Local Health Integration Networks, provided GTA Rehab Network members with the opportunity to learn about its new patient flow support tools; identify other new tools/resources or standard policies for enhancing patient flow; review the newly piloted Bed Holding Policy and its evaluation results; engage in discussion on patient flow issues including current challenges and enablers in the referral process; and initiate a discussion on the identification and use of system-wide performance indicators for rehabilitation.<sup>10</sup>

Through discussion, stakeholders identified the following issues pertaining to patient flow:

- There was overwhelming support (97%) for the GTA Rehab Network to lead an initiative that would address the needs of medically complex patients within ALC, beginning with those who have sustained a hip fracture, to leverage (not duplicate) the work completed to date in implementing the FHRAT model.
- There is a perception among acute care hospitals outside of Toronto that there is a lack of equitable access to LTLD and CCC programs within Toronto. This perception may be fostered as a result of the partnerships between acute care and rehab hospitals that were established through the Flo' Collaborative.
- Obtaining pertinent referral information continues to be a problem affecting referral processes and efficiency including lengthy response times.
- There are not enough nor appropriate resources for mental health issues in geriatrics.
- A standardized discharge policy re: application to LTC is required across all programs.
- There is a need to look at supports for patient flow beyond the narrow definition of healthcare (i.e. accessibility of environment, social support, impact of mental health and aging and lifestyle: substance abuse/use).
- There are inconsistencies in services/resources that are available to patients across various LHINs.

#### Winter 2010

On February 25, 2010, the Network brought together acute care and rehab/CCC stakeholders via teleconference for the first Rehab/CCC Referral System Rounds. The objective of the rounds was to provide a communication mechanism for acute care referrers and rehab/CCC providers to discuss challenging, complex referrals and develop innovative strategies to enable timely transfers to the alternate level of care required. The rounds will also be used to strategize around what is required by organizations and by the system to better meet the needs of these patients. Feedback from participants indicated support for holding face-to-face forums on a quarterly basis. A forum specific to the care of patients with hip fractures will be held in June. Another forum will be held in the fall to improve how and which information is provided in referrals to reduce the number of times that additional information is requested.

### **3.3 DELIVERABLE: Considerations for System Performance Data Indicators**

The TC LHIN RM&R system tracks a number of data points related to the referral of patients to inpatient rehabilitation and CCC. The GTA Rehab Network identified a number of questions that reflect key issues related to patient flow. These questions were used to help guide its recommendations regarding a core data set that is most relevant to supporting system performance management pertaining to patient

<sup>9</sup> Participants included stakeholders from acute care teaching hospitals (4), community hospitals (17), rehab/CCC (33), CCAC (2) and LHINs (2); other (4)

<sup>10</sup> This discussion on performance indicators was facilitated by the keynote speaker, Scott Ovenden, Quality Improvement Consultant with the Centre for Healthcare Quality Improvement.

flow. (See Table 2) It is important to note that monitoring such indicators should be done within the context of the others – for example, monitoring of length of stay alone in absence of understanding patient complexity and number of patients seen can drive performance in a direction that is not consistent with system goals of patient flow and reduction of ALC.

**Table 2**

Key Issues in Patient Flow	Related Questions
<i>Clinical Utilization</i>	<ul style="list-style-type: none"> <li>▪ How many patients are being referred to rehab and CCC and to which programs?</li> <li>▪ How many patients are admitted to rehab and CCC and to which programs?</li> </ul>
<i>Efficiency in the Referral Process</i>	<ul style="list-style-type: none"> <li>▪ How quickly are referrals processed?</li> </ul>
<i>Access to Services</i>	<ul style="list-style-type: none"> <li>▪ Which referrals are accepted and denied to inpatient rehab and CCC?</li> <li>▪ How quickly are patients able to access rehab and CCC?</li> <li>▪ How many medically complex patients are getting access to rehab?</li> </ul>

Considerations regarding possible indicators that can be used to address these questions are identified below. The table also indicates if targets/benchmarks have been established against which these indicators can be measured.

***A Family of Indicators:*** It is recommended that ‘a family of indicators’ addressing the questions related to clinical utilization, efficiency in the referral process and access to services be considered to measure patient flow. (See Table 2) The indicators proposed to measure access also include a focus on the medically complex patients as these are the patients who may wait longer for services or may be denied access to services.

Indicators related to quality of care and cost effectiveness are not directly related to patient flow and have not been included in Table 2 for the purpose of this report. However, the measurement of these aspects of care is equally important.

Considerations for the measurement of quality include but are not limited to:

- ▶ outcome indicators to measure functional gains
- ▶ tracking discharge destination to determine the number of patients able to return to the community
- ▶ overall satisfaction of patients pertaining to the care that is received
- ▶ staffing levels appropriate to the rehab and/or care requirements of the patient

Considerations for the measurements of cost effectiveness include but are not limited to:

- ▶ length of stay efficiency score
- ▶ discharge to the community
- ▶ disposition at follow-up (e.g. at 6 months, 1 year)

It is imperative that the choice of quality indicators and indicators to measure cost-effectiveness should be done through collaboration with those who can provide important and relevant contextual information and expertise to ensure that the indicators selected are relevant, reliable and meaningful. Current indicators/measures (e.g. occupancy rates, length of stay) should also be reviewed as these may be ineffective, irrelevant or actually serve as a disincentive to supporting patient flow and acceptance of medically complex patients.

***Establishing Benchmarks:***

While it is important to identify a core set of indicators for patient flow, it is equally important to identify a set of benchmarks against which the indicators can be measured. However, this first necessitates a thorough understanding of current system performance that is based on accurate and reliable data before the information can be used as a basis for establishing benchmarks (and/or revising current benchmarks) for performance measurement. While the GTA Rehab Network has conducted analyses of the monthly RM&R reports, there have been several process and technical issues with RM&R that have

limited the reliability of the data to date. (See Section 3.1, Step Two, Data Limitations) The monthly RM&R reports underwent a significant review and revision process from August – October, to improve the quality of the data reported and as a result, the first revised report (for August 2009 referral data) became available in mid-October. Further, the monthly data reports provide an abridged version of the information as the report does not include organization-specific data at this time.<sup>11</sup>

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<sup>11</sup> The current monthly RM&R reports do not include organization-specific data as data sharing agreements have not been finalized.



Patient Flow Indicators:

Table 3 below outlines considerations regarding system performance indicators that focus on a select aspect of the health system: indicators related to the transition of patients from acute care to inpatient rehab and complex continuing care.

**Table 3**

Patient Flow Indicators
<p><b>Process Indicators Measuring Clinical Utilization (Who is being referred?)</b></p> <ul style="list-style-type: none"> <li>▶ TC LHIN RM&amp;R monthly data reports monitor referral volumes                             <ul style="list-style-type: none"> <li>▪ Number of referrals submitted for HTSD, LTLD, CCC (In future, report by population groups for each program type)</li> <li>▪ Number of clients referred. (In future, report number of clients for each program and population type, average age, sex)</li> </ul> </li> <li>▶ To capture information on patients who are not referred through RM&amp;R, each organization would need to report the number of referrals to HTSD, LTLD and CCC that are received from referral sources outside of the RM&amp;R system.</li> </ul>
<p><b>Process Indicators Measuring Efficiency in Referral Processes (How quickly are referrals processed?)</b></p> <ul style="list-style-type: none"> <li>▶ Use of TC LHIN monthly RM&amp;R data reports monitor how quickly referrals are submitted and responded to and how long patients wait to be admitted once accepted.                             <ul style="list-style-type: none"> <li>▪ % of referrals that meet 2 business day response time benchmark from date referral sent to first referral response (including send back response)</li> <li>▪ % of referrals that meet benchmark (no benchmark established) for Decision Time (from date referral sent to final decision)</li> <li>▪ % of referrals that meet benchmark (no benchmark established) for Wait Time<sub>1</sub> (from date referral sent to date decision received – as defined by RM&amp;R)</li> <li>▪ % of referrals pending for more than 3 days</li> <li>▪ % of referrals sent back for incomplete and inconsistent information</li> </ul> </li> </ul>
<p><b>Process Indicators Measuring Access (Who is accepted? Who is denied?)</b></p> <ul style="list-style-type: none"> <li>▶ TC LHIN RM&amp;R monthly data reports monitor who is and is not getting access to services and reasons for not getting access relative to the total number of referrals submitted.                             <ul style="list-style-type: none"> <li>▪ % of referrals that are accepted</li> <li>▪ % of patients with special needs whose referrals are denied by all programs</li> <li>▪ % of referrals denied because: (Breakdown of some of these categories into subcategories is not included for the purpose of brevity)                                     <ul style="list-style-type: none"> <li>• Patient functional status too high for inpatient rehab</li> <li>• Medically unstable</li> <li>• Psychiatric needs cannot be accommodated</li> <li>• Secured unit required/not available</li> <li>• Behavioural care needs cannot be met</li> <li>• Use of restraints/need for observer cannot be accommodated</li> <li>• Medical/nursing needs cannot be accommodated</li> </ul> </li> </ul> </li> </ul>

Patient Flow Indicators
<ul style="list-style-type: none"> <li>• No demonstrated potential to benefit from rehab</li> <li>• Equipment cannot be accommodated</li> <li>• Care requirements are not appropriate for CCC</li> </ul> <p>▶ To capture information on accepted and denied patients who are not processed through RM&amp;R, each organization would need to report the number of referrals accepted and denied to HTSD, LTLD and CCC that are received from referral sources outside of the RM&amp;R system.</p>
<p><b>Process Indicators Measuring Timeliness to Access (How quickly are patients able to access rehab and CCC?)</b></p> <p>▶ TC LHIN RM&amp;R monthly data reports monitor wait times for accessing services once a patient is rehab or CCC ready.</p> <ul style="list-style-type: none"> <li>▪ % of referrals that meet benchmark (no benchmark established) for Wait Time<sub>2</sub> (i.e. from date decision received to date of admission)</li> <li>▪ % of referrals that meet benchmark (no benchmark established) for Total Wait Time (i.e. from point of rehab referral to date of admission)</li> </ul>
<p><b>Indicators to measure how many patients are being seen in rehab and CCC</b></p> <p>▶ TC LHIN RM&amp;R monthly data reports monitor the number of patients who are admitted relative to total number of referrals.</p> <ul style="list-style-type: none"> <li>▪ % of clients who are admitted to HTSD, LTLD and CCC</li> </ul> <p>▶ To capture information on patients who are not referred through RM&amp;R, each organization would need to report the number of admissions to HTSD, LTLD and CCC that are received from referral sources outside of the RM&amp;R system.</p>
<p><b>Indicators to measure length of stay of patients in HTSD, LTLD and CCC</b></p> <p>▶ Use current reporting requirements to measure length of stay in each program type (i.e. HTSD, LTLD and CCC) and by population group</p> <ul style="list-style-type: none"> <li>▪ Average length of stay</li> </ul>
<p><b>Indicators to measure how many medically complex patients are getting access to rehab?</b></p> <p>▶ Use current NRS reporting requirements to measure admission FIM™ scores and length of stay as a suggested proxy for medical complexity. For example,</p> <ul style="list-style-type: none"> <li>▪ % of patients admitted to inpatient rehab with admission FIM™ score &lt;60?</li> <li>▪ % of patients admitted to inpatient rehab with length of stay &gt;35 days?</li> <li>▪ Likely need other indicators beyond admission FIM as a measure of patient complexity – can defer to suggestion for weighted cases as per RPG/FRGs</li> </ul>

The indicators proposed can be used to monitor and measure if rehab/CCC services are accessible to patients and if the processes used to get patients to these services are as efficient as possible. As patient flow is a shared responsibility between acute care, rehab/CCC hospitals and CCAC, it is important to recognize that enhancing patient flow and maximizing referral process efficiencies rely on more than the monitoring of indicators extracted from an electronic referral system. The establishment of effective relationships and communication between the sending and receiving organizations that is based on mutual trust and collaboration are equally important to supporting patient flow.

The indicators proposed in this report have been discussed with members of the GTA Rehab Network's Patient Access and Flow committee, who represent acute care, rehab, CCC and CCAC. Although outside the scope of the project charter, considerations regarding the selection of indicators to measure the quality and cost-effectiveness of services have been provided as well. Broader stakeholder consultation and collaboration in the selection of meaningful indicators to measure patient flow, outcomes and cost-effectiveness is required.

### **3.4 DELIVERABLE: Key Findings / Trends from RM&R Data Analysis – August 2009 to February 2010**

The data analyses for the months of August through to February highlight several preliminary trends. As these are based on seven months of data, during which time several issues affecting data integrity were identified and adjustments were made to the functionality of the RM&R system, these trends should be monitored over subsequent RM&R monthly reports to determine if they are sustained.

#### **Caveats:**

The number of referrals accepted and waiting and the associated waiting time categories are inflated as a result of a technical problem with the referral application discovered after the release of the December 2009 report. Extraneous referrals for clients admitted have not been automatically cancelled and removed from the count. This problem was corrected in February and is expected to be reflected in the March monthly RM&R report, to be released in mid April.

In January, the GTA Rehab Network also learned that the RM&R system was including some admitted referrals in the calculation of the number of referrals accepted and waiting. This was corrected for the January report.

1. **Referral Volumes:** The average number of referrals per month for HTSD, LTLD and CCC has been 946 referrals. The average number of referrals by program type has been as follows:  
Average number of referrals per month by program type:
  - HTSD = 682 referrals (72%)
  - LTLD = 203 referrals (22%)
  - CCC = 61 referrals (6%)

From August 2009 to February 2010, on average 24% (Range: 17 - 29%) of the total number of referrals received during a reporting month resulted in an admission during the same reporting month. On average, 2.6 referrals are received per client each month (Range: 2.3 - 2.8)

2. **Response Times:** The overall average response time for rehab/CCC across HTSD, LTLD and CCC programs has fluctuated between 2 days (at benchmark) and 3 days (above benchmark) from August to January as summarized in the table below. (No overall average response time was reported in February)

(Note: RM&R reports response times in *calendar* days and the benchmark established by the GTA Rehab Network is measured in *business* days and as such, some programs may be meeting the benchmark.)

A comparison across programs types shows that January was the first month in which the average response time across all HTSD, LTLD and CCC programs was 2 days (at benchmark). Since August, on average, HTSD programs alone have met the benchmark consistently.

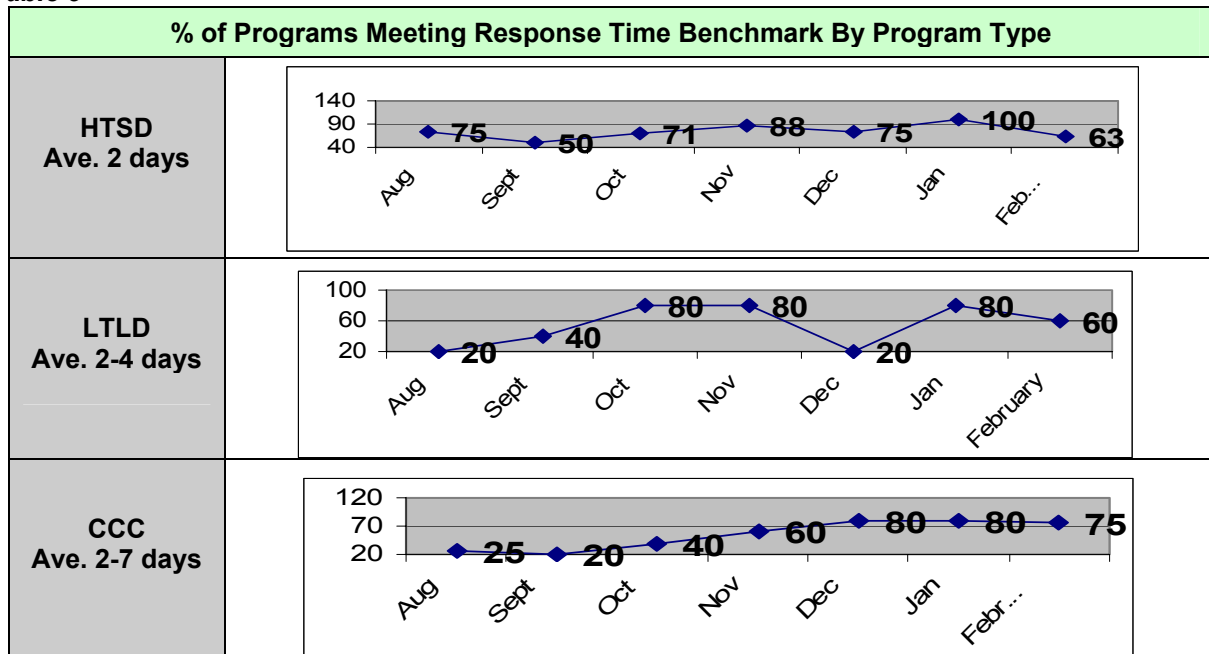
A comparison of average response times for individual programs *within* HTSD, LTLD and CCC in August, September, October and November shows steady improvement with an increasing number of programs *within* HTSD, LTLD and CCC meeting the benchmark (i.e. by November,

78% of programs met the response time benchmark). This rate dropped to 61% of the programs meeting the benchmark in December, but improved markedly to 89% of 18 programs meeting the benchmark in January. However, the rate dropped again in February to 69% of 16 programs. Further monitoring should be done to track if there is continued improvement in the average response time in subsequent months. Average response times by program type are summarized in Table 4 and Table 5 below:

**Table 4**

Response Time (Average number of days)					
	HTSD	LTLD	CCC	Overall Average Response Time across HTSD, LTLD and CCC programs	Number of programs spanning HTSD, LTLD and CCC programs that meet the response time benchmark
<b>August</b>	2 days (at benchmark)	4 days (above benchmark)	6 days (above benchmark)	3 days	▶ 8 of 17 programs (47%) met the 2 day benchmark in August
<b>September</b>	2 days (at benchmark)	3 days (above benchmark)	7 days (above benchmark)	3 days	▶ 8 of 18 programs (44%) met the 2 day benchmark in September.
<b>October</b>	2 days (at benchmark)	2 days (at benchmark)	4 days (above benchmark)	2 days	▶ 11 of 17 programs (65%) spanning met the 2 day benchmark in October.
<b>November</b>	2 days (at benchmark)	4 days (above benchmark)	4 days (above benchmark)	3 days	▶ 14 of 18 programs (78%) spanning met the 2 day benchmark in November.
<b>December</b>	2 days (at benchmark)	3 days (above benchmark)	3 days (above benchmark)	2 days	▶ 11 of 18 programs (61%) met the 2 day benchmark in December.
<b>January</b>	2 days (at benchmark)	2 days (at benchmark)	2 days (at benchmark)	2 days	▶ 16 of 18 programs (89%) met the 2 day benchmark in January.
<b>February</b>	2 days (at benchmark)	3 days (above benchmark)	2 days (at benchmark)	Not reported	▶ 11 of 16 programs (69%) met the 2 day benchmark in February.

**Table 5**



*Impact:* Delays in responding to referrals slows down the overall referral process and can result in increasing ALC days.

3. **Pending Referrals:** There is an increasing number of referrals that are pending (i.e. waiting for an initial response from the receiving facility or a response to a send back from either the sending or receiving facility). By February 28<sup>th</sup>, there were 881 referrals that were waiting for a response to either an initial referral or a send back, up from 511 referrals that were waiting for a response in January; 376 in December, 281 in November, 180 in October, 140 in September and 97 in August. (Note: Tracking of pending referrals began in August. Numbers may be inflated as extraneous referrals for clients admitted were not automatically cancelled and removed from the count until mid February and will be applied to the March report.)

*Impact:* Without a response, the referral process cannot move forward to finalize a referral decision. The most frequent reason for sending back a referral has been that additional information is needed. Anecdotally, we have been told that this request is often made because the information fields in the referral have not been completed or because the information provided is inconsistent or contradictory to information elsewhere within the referral. The GTA Rehab Network will be working with its members to identify key sets of “information cues” that can be embedded within the referral to prompt referrers in providing the required details regarding the patient’s care needs and functional status.

4. **Wait Time:** The average wait time<sup>12</sup> by program has been fairly consistent over the past 7 months for HTSD and LTLD as follows:
- HTSD: 3 – 5 days
  - LTLD: 7 – 14 days
  - For CCC, the average wait time fluctuated between 18 – 27 days in August, September, October and December. The average wait time decreased markedly in November to 8 days, 7 days in January and 10 days in February.

For those patients who have been admitted, the average wait times for HTSD and LTLD are not overly long and are improving for CCC. However, these wait times do not include the referrals of patients who *are accepted and waiting* for admission. The tracking of average wait times should not preclude focused attention on this other cohort of patients who cannot access rehab/CCC quickly.

*Impact:* Understanding and addressing the reasons for why patients wait for extended periods once accepted is important to determine what the barriers to access are. Currently, RM&R does not track reasons for waiting.

Over the past 7 months, the following programs were most frequently found to have the longest average wait times: (See Table 6)

- HTSD: Geriatric rehab
- LTLD: Geriatric rehab
- CCC: General CCC

**Table 6**

Programs with the Longest Average Wait Times			
	HTSD Program/Average Wait Time	LTLD Program/Average Wait Time	CCC Program/Average Wait Time
<b>August</b>	Geriatric / 5 days	General / 15 days	General / 51 days
<b>September</b>	Geriatric / 7 days	Transitional / 20 days	General / 21 days
<b>October</b>	HTSD Other/ 8 days	General / 9 days	General / 28 days
<b>November</b>	Geriatric / 5 days	Geriatric / 24 days	Neuro complex Care / 21 days
<b>December</b>	Geriatric / 5 days	Geriatric / 23 days	General / 27 days
<b>January</b>	Amputee / 9 days	General / 20 days	Dialysis / 14 days
<b>February</b>	General/Medicine / 12 days and Geriatric / 11 days	Geriatric / 42 days	General / 12 days
<b>Most frequently cited program with longest average wait time</b>	Geriatric rehab with average wait time from 5 – 11 days	Geriatric rehab with average wait time from 23 – 42 days and General LTLD with average wait time from 9 – 20 days	General CCC with average wait time from 12 – 51 days

<sup>12</sup> Wait time = Date of first acceptance to the program within the receiving facility to date of admission in days.

5. Referrals Accepted and Waiting: The trend over the past 7 months has indicated that there is a substantial number of referrals that have been accepted and are waiting for admission for an extended period of time as follows:
- 86% of accepted HTSD referrals are waiting more than 7 days
  - 86% of LTLD referrals are waiting 14 or more days
  - 79% of CCC referrals are waiting 14 or more days

While these extended waiting times may be due to capacity issues in rehab and CCC, there are three other factors that contribute to this situation and prevent the use of this data for drawing any conclusions around capacity.

(i) Technical Issues: The number of referrals accepted and waiting are inflated as a result of a technical problem with the referral application discovered after the release of the December report. Extraneous referrals for clients admitted have not been automatically cancelled and removed from the count.

(ii) Data Inputting Issues at Acute Care: If a patient is repatriated to a hospital outside of the RM&R system to await admission to a rehab/CCC facility within RM&R and possibly elsewhere, his/her referrals will remain in the RM&R system as “*accepted and waiting*” until the patient is admitted to an RM&R rehab/CCC hospital. If the patient goes to a non-RM&R facility or decides to forego inpatient rehab, the RM&R system requires that acute care cancel the RM&R referral. Given the high rate of patient turnover on an acute care unit, acute care does not have the resources to track patients once they are discharged from their unit to determine if they have been admitted to rehab/CCC as originally planned. It is purported that this situation contributes considerably to inflating the number of referrals accepted and waiting.

(iii) Data Inputting Issues at Rehab/CCC: When a patient is admitted to a rehab/CCC facility within RM&R, the admitting facility is required to register the patient's admission in RM&R. When this is done, other referrals will be automatically cancelled by RM&R. If the patient is not registered as “admitted”, the other referrals will not be cancelled. The extent of referrals not registering admitted patients is likely very small.

*Impact*: The extent to which capacity is affecting wait times cannot be accurately determined until these data inputting issues are investigated and rectified as required. In addition, RM&R does not track the reasons for waiting and as such, this limits our ability to determine where and what additional resources are needed to increase timely access to rehab/CCC and improve patient flow.

6. Denial Rates: Over the past 7 months, approximately 20 – 26% of referrals across all programs are denied by at least one facility. Denial rates were highest for referrals to CCC in August, September, November, December and January representing approximately 35% – 50% of CCC referrals. The denial rate in CCC has been typically almost twice as high as the rate in the other program types, with the exception of October when the denial rate and number of referrals submitted were lower. (February 35%; January 40%; December 44%; November 46%; October 28%; September 50%; and August 41%). It should be noted that a high denial rate is not necessarily problematic. For example, denial rates can indicate that inappropriate referrals based on program criteria or best practice recommendations are being sent to a program (e.g. It is recommended that patients with a mild stroke be seen in an outpatient or home-based setting).<sup>13</sup>

Over the past 7 months, the following programs were most frequently found to have highest rate of denial:

- HTSD: Geriatric rehab
- LTLD: Geriatric rehab
- CCC: General CCC

From August to February, a total of 66 referrals were denied by all programs. (See Appendix B) On average, the proportion of referrals by program type was as follows:

<sup>13</sup> See *Canadian Best Practice Recommendations for Stroke Care: (updated 2008)*. Canadian Stroke Network/Heart and Stroke Foundation of Canada. CMAJ 2008;179(12 SUPPL):E1-E93.

- HTSD: 59%
  - Of these, highest frequency were referrals to HTSD – other (39%); MSK (23%) and Geriatric (15%)
- LTLD: 21%
  - Of these, highest frequency were referrals to Neuro (36%); Geriatric (29%) and General (21%)
- CCC: 20%
  - Of these, highest frequency were referrals to General (46%), Complex Medical (23%) and Dialysis (23%)

The most frequent reasons for denial of referrals by all programs were that the patient is “not rehab ready” and “medical needs cannot be accommodated”. (See Table 7) Reasons for “medical needs cannot be accommodated” have typically fallen under the “other” category. (See Appendix C) A manual audit of the “other” category from August to February was conducted. Of 66 referrals denied by all programs during this period, 13 or 20% were denied because “Medical needs cannot be accommodated – other.” An examination of these referrals revealed a variety of reasons given in this category largely due to the patient being deemed not appropriate for the specific programs applied to or not appropriate for rehab in general. The need for haemodialysis was cited as a barrier for one referral. In another instance, the patient declined the program that was recommended. (See Appendix D)

**Table 7**

Most Frequent Reasons For Denial of Referrals by All Organizations			
	HTSD	LTLD	CCC
<b>August*</b>	<ul style="list-style-type: none"> <li>▪ Medical needs cannot be accommodated (44% of 32 referrals)</li> <li>▪ Not rehab ready (28% of 32 referrals)</li> </ul>		
<b>September*</b>	<ul style="list-style-type: none"> <li>▪ Medical needs cannot be accommodated (48% of 29 referrals)</li> <li>▪ Not rehab ready (38% of 29 referrals)</li> </ul>		
<b>October</b>	Not rehab ready (38% of 8 referrals)	Not rehab ready (86% of 7 referrals)	Not appropriate for CCC (60% of 5 referrals)
<b>November</b>	Not rehab ready (71% of 14 referrals)	Not rehab ready (60% of 5 referrals)	Medical needs cannot be accommodated (75% of 4 referrals)
<b>December</b>	Not rehab ready (78% of 9 referrals)	Not rehab ready (75% of 4 referrals)	Medical needs cannot be accommodated (75% of 4 referrals)
<b>January</b>	Not rehab ready (100% of 2 referrals)	Medical needs cannot be accommodated (64% of 11 referrals)	Medical needs cannot be accommodated (100% of 1 referral)
<b>February</b>	Not rehab ready (73% of 11 referrals)	Not rehab ready (75% of 4 referrals)	Behavioural needs cannot be met (50% of 2 referrals) and Not appropriate for CCC (50% of 2 referrals)

\* Number of denials undifferentiated by program type (i.e. HTSD, LTLD and CCC) in TC LHIN reports for August and September

**Impact:** Denials by some programs, even though patients may be accepted by another program, can contribute to overall delays in the referral process. Although the number of referrals denied by all programs each month is relatively small, the impact of these patients remaining in acute care is not insignificant. The GTA Rehab Network will be working with its members to develop clearer criteria for determining rehab readiness to help reduce the discrepancy that exists between the acute care and rehab perspectives.

7. Patients referred to Geriatric Rehab: These patients typically have:
  - ▶ Longer waits for a response to their referrals to LTLD rehab (i.e. higher average response time)
  - ▶ Relatively higher rates of denial than rehab programs for other populations.

- ▶ Longer waits for admission to HTSD rehab once their referral is accepted.<sup>14</sup>

Note: The data from August 2009 to February 2010 indicates that patients aged 70 or older represent approximately 64% of the referrals submitted through RM&R. The breakdown of which programs these referrals are for (e.g. HTSD, LTLD, and CCC) is unavailable.

The GTA Rehab Network recommends that it continue to analyze the monthly RM&R data reports and monitor the preliminary trends identified. In absence of organization-specific data, the analysis is currently limited in its depth relative to established benchmarks for performance (e.g., referral response by organization/program). The GTA Rehab Network would continue to conduct its analysis of the data and share its analysis with the Patient Access and Flow Committee and other stakeholders to support utilization, optimize data quality and identify other system factors that need to be considered in analysis of the data.

### **3.5 DELIVERABLE: Considerations for Capacity Overlaps/Gaps for Inpatient Rehab/CCC**

Current Demand and Capacity: Within the Toronto Central LHIN, there are 587 adult designated rehab beds, 335 LTLD rehab beds (within CCC) and 1372 CCC beds that accept external referrals.<sup>15</sup> The estimated demand for these beds, based solely on the RM&R data from August 1<sup>st</sup>, 2009 to February 28, 2010 is as follows:

- 587 adult designated rehab beds<sup>16</sup> → to accommodate an average 682 referrals per month
- 335 LTLD rehab beds → to accommodate an average 203 referrals per month
- 1372 CCC beds → to accommodate an average 61 referrals per month<sup>17</sup>

It should be noted that this estimation of demand does not include the demand for services from referral sources that are not sent through RM&R, including paper-based and other electronic referral systems (e.g. e-Stroke Rehab Referral system). It is also important to recognize when considering demand and capacity that examination of the referral and bed numbers alone do not provide information on the variation in length of stay across programs, which also plays a part in how quickly patients access rehab/CCC and move through the system.

The average wait time per program type is:

- HTSD: 3 – 5 days
  - The longest average wait time in HTSD has typically been for Geriatric rehab with an average wait time from 5 – 7 days.
- LTLD: 7 – 14 days
  - In LTLD, the longest average wait time has most frequently been for General LTLD with an average wait time from 9 – 20 days.
- CCC: The average wait time fluctuated between 18 – 27 days in August, September, October and December. The average wait time decreased markedly in November to 8 days, 7 days in January and 10 days in February.
  - In CCC, the longest average wait time has been for General CCC with an average wait time from 12 – 51 days.

An “acceptable” wait time for services, especially for programs that have a longer length of stay (i.e. LTLD and CCC) has not been determined.

It is important to distinguish between the “wait time” information in RM&R and the “waiting time” for accepted referrals. In the RM&R report, wait times refer to referrals associated with patients who have been admitted. However, each month, there are a number of referrals that remain “*accepted and*

<sup>14</sup> The number of referrals accepted and waiting and the associated waiting time categories are inflated as a result of a technical problem with the referral application discovered after the release of the December report. Extraneous referrals for clients admitted have not been automatically cancelled and removed from the count. The correction of this problem will be reflected in the March report.

<sup>15</sup> Based on GTA Rehab Network 2009 bed count of beds within the TC LHIN where external referrals are accepted. The CCC bed count includes 335 CCC beds at Sunnybrook Health Sciences Centre for veterans only.

<sup>16</sup> Accepting external referrals

<sup>17</sup> Average number of referrals does not include referrals to palliative care in CCC.



*waiting*” by the end of the reporting period, which are not included in the calculation of wait time. This distinction is important when reviewing average wait times of admitted referrals as these times *do not* include the many referrals that are waiting to be admitted. The number of accepted and waiting referrals reported in the RM&R system has not been accurately captured and is inflated due to a technical problem (i.e. the extraneous “accepted and waiting” referrals for clients admitted to rehab/CCC have not been automatically deleted and instead have been included in the count). As a result, the extent to which there are patients waiting for admission for extended periods of time cannot be accurately determined based on the data that is currently available.<sup>18</sup>

*Who are these patients waiting for admission for extended periods?*

From the RM&R data, the most frequent special needs of patients with extended waiting times following acceptance (i.e. more than 14 days) have been:

- HTSD: Skin condition; equipment needs, and oxygen
- LTLD: Skin condition; equipment needs; and IV
- CCC: Enteral feeds; skin condition; and equipment needs

Discussion during the SIMS teleconference rounds with acute care and rehab/CCC representatives based on their front-line experience with patients referred from RM&R facilities and non- RM&R facilities (Fall 2008 / Winter 2009) suggested that patients with extended waits in ALC for rehab/CCC (i.e. > 1 week) typically have the following special needs: wound care and infection control, tracheostomy care, dialysis, bariatric equipment and oxygen.

While Rehab/CCC units have the expertise and resources to accommodate many different types of special needs, the capacity within rehab/CCC units to meet current demands *at any one time* may be limited by:

1. Availability of equipment
2. Environmental set-up (e.g. not all units can accommodate oxygen, infection control needs or need for secured units)
3. Human resources required to care for multiple patients with special needs at one time
4. Lack of diagnostic services on site

The above information suggests that *alternate* capacity is likely needed to accommodate the medical/special needs of patients (e.g. via more skilled nursing and availability of equipment to meet the heavy care needs of patients) so that more patients can be accepted at one time. However, it would be very useful for RM&R to capture information on reasons for why patients wait once accepted to help identify targeted solutions.

*Is new capacity needed?*

Patients who typically have difficulty accessing rehab/CCC are patients who are medically complex (e.g. defined by the Toronto Academic Health Science Network as those with multi-system medical conditions and co-morbidities such as cognitive, behavioural, psychiatric issues, long-term ventilation needs, dialysis, wound care, bariatric needs, nervous system disorders requiring LTLD rehab and frail and elderly)<sup>19</sup>

A scan of current rehab/CCC programs within the TC LHIN that are focused on providing care to medically complex patients indicates that the approximate number of beds that is available for these patients is as follows.<sup>20</sup>

- HTSD: 428 beds<sup>21</sup> (representing 73% of the total number of HTSD beds in the TC LHIN)
- LTLD: 340 beds<sup>22</sup> (representing 100% of LTLD bed in the TC LHIN)

<sup>18</sup> The technical problem was corrected at the end of February and will be reflected in the data for March, which will be released in April.

<sup>19</sup> Shifting the Paradigm: A call for centralized access management for medically complex patients in transition. Prepared by the Medically Complex Work Group – a joint initiative of the TC LHIN and the Toronto Academic Health Science Network

<sup>20</sup> Based on a review of the GTA Rehab Networks Quick Reference Guide / Version 1.0 / June 2009.

<sup>21</sup> Number includes beds in ABI, Amputee, Geriatric, Behavioural, Neuro, Stroke, Complex MSK, Oncology, Spinal Cord rehab programs within the TC LHIN as listed in the Quick Reference Guide.

<sup>22</sup> Number includes all LTLD beds within the TC LHIN as listed in the Quick Reference Guide

- CCC: 401 beds (representing 29% of CCC beds in the TC LHIN)<sup>23</sup>

In order to determine if new capacity is needed, the following questions should be considered:

- ▶ Why are patients waitlisted?
  - Currently, RM&R does not track this information. For example, are patients waitlisted because the unit cannot accept another patient who has many special care needs and requires heavy care or is it because there is no bed available? It would be important to track this information by organization, program type (i.e. HTSD vs. LTLD vs. CCC) and by population (i.e. ABI, MSK, Geriatric etc.) to determine exactly where new capacity may be needed.
- ▶ What is an “acceptable” wait time?
  - An “acceptable” wait time for services has not been determined but should be, particularly for programs that have a longer length of stay (i.e. HTSD Geriatric rehab; General LTLD rehab; General CCC services).
- ▶ How many medically complex patients can one unit accommodate at any one time?
  - Is it possible to identify a maximum “threshold” or “ratio” of heavy care patients (i.e. medically complex patients) to lighter care patients on a unit and use this “ratio” to determine the associated staffing and equipment resources that are needed on a unit? This information could then be used to compare these requirements to current funding and demand for services and conduct a gap analysis.
  - Some organizations are beginning to conduct case-costing reviews to better understand the resources required to care for patients in particular programs.
- ▶ Which patients are being denied by all programs?
  - While we have a good understanding about the reasons for denial within HTSD, LTLD and CCC, this information is not broken down by population (i.e. ABI, MSK, Geriatric etc.) or by organization.
- ▶ How can CCC beds occupied by ALC patients be freed up?
  - The number of ALC patients in CCC who are unable to quickly access the appropriate level of care in the community requires that the “capacity question” for rehab/CCC must include consideration of the need for additional capacity in the community to relieve these ALC pressures and free up beds within rehab/CCC.
  - Through a review conducted collaboratively by the GTA Rehab Network and the Toronto Central CCAC in 2009, approximately 20% of CCC beds are occupied by patients awaiting an alternate level of care, of whom 94% are waiting for LTC. Approximately 30 - 50% of patients waiting for LTC do not require LTC but are unable to access the necessary services within the community to enable them to return home.<sup>24</sup> It is estimated that up to 50% of patients waiting for LTC could be accommodated at home with enhanced community support services/resources.<sup>25</sup>
  - Some of these CCC-ALC patients may include patients transferred from a HTSD or LTLD program within the same organization to await discharge to the community thus transferring the ALC issue from one type of bed to another.
- ▶ What is the demand for services for populations not tracked by RM&R and from referral sources that do not use the RM&R system to make referrals?

<sup>23</sup> Number includes beds in specialized CCC programs (i.e. other than General CCC beds) within the TC LHIN as listed in the Quick Reference Guide.

<sup>24</sup> TC LHIN CCC/ALC Value & Affordability Task Force, 2009. Based on review of SIMS snapshots, July 1, 2009 (Start of new Provincial ALC Definition) to August 18, 2009. Note: SIMS ALC snapshots do not include Runnymede or Baycrest, which have CCC programs.

<sup>25</sup> Existing CCAC resources include services such as: personal support services for activities of daily living, nursing services for complex care needs, OT and PT services for home safety and rehabilitation, among others.

- Populations not tracked by RM&R include ABI referrals; pre-booked referrals (e.g. MSK referrals); referrals to Geriatric Psychiatry, referrals to Palliative Care by acute care.
- Referral sources outside of the RM&R system include E-Stroke; paper-based referrals from organizations outside of the TC LHIN or other referrers.

### **3.6 DELIVERABLE: Cross LHIN Issues**

While patients who reside outside of the TC LHIN often receive acute care and rehabilitation within the TC LHIN, there are times when they may also receive or require care within their home LHIN in the interim between acute care and rehab or following discharge from inpatient rehab/CCC. These types of situations rely on clear communication and follow-up with organizations outside of the TC LHIN and access to programs in another LHIN to achieve a smooth transition of care. However, this smooth transition is often compromised due to current follow-up practices, eligibility/admission criteria of programs and amount of resources available in the home LHIN as illustrated below.

- ▶ Communication of Transfer/Repatriation in Referral Process: A patient in acute care within the TC LHIN may be repatriated to a community hospital outside of the TC LHIN to await admission to a rehab/CCC hospital within the TC LHIN. Once the patient is discharged from the TC LHIN acute care hospital, there is little or no follow-up between the acute care hospital and the community hospital and as a result, any change in the patient's discharge destination from the initial referral, should it occur, are not updated in the referral. When a rehab/CCC bed is available, it may be difficult for the rehab/CCC hospital to locate the patient and make the bed offer if the transfer has not been communicated to them by acute care or if the patient is no longer at the community hospital or no longer needs the rehab/CCC bed.

This situation also affects the electronic tracking of referrals in RM&R. If the referral for rehab/CCC is no longer required, it is the responsibility of the acute care hospital to cancel the referral in RM&R. It is reported that this step is frequently missed and as a result, a referral may appear to be "accepted and waiting" or "pending" when in fact, the referral is no longer required.

- ▶ Restrictive Eligibility/Admission Criteria: It is sometimes difficult to access services in the patient's home LHIN if the acute care treatment was received within the TC LHIN. Some hospital programs outside of the TC LHIN only accept internal referrals even if the patient lives in their catchment area. For example, access to outpatient rehab services or inpatient rehab is often restricted to patients who have a physician on staff of the hospital or if the surgery was done in the hospital within the home LHIN. This presents a barrier for discharge planners in the TC LHIN and often delays discharge.
- ▶ Variability in Amount of Resources Available: There are differences in the type and amount of resources/services available in CCACs across different LHINs affecting wait times for services in the home LHIN and potentially discharges from TC LHIN acute care or rehab hospitals.

### **3.7 DELIVERABLE: Program/System Level Changes**

The Network's ability to identify factors contributing to delays in system flow and opportunities for program/system changes and process efficiencies has been limited for the following reasons. To date, the Network has not been given permission to analyze and report organizational specific data. Although the Executive Director may view RM&R organizational level reports, these reports cannot be shared and discussed with organizations to fully identify factors contributing to delays in flow and opportunities for efficiencies at organizational and program levels. In addition, data inputting and quality issues resulting in inflated data as discussed earlier in this report, have limited the reliability of the data to some extent and thus the analysis that could be conducted.

#### 4.0 KEY RECOMMENDATIONS TO IMPROVE DATA QUALITY AND REPORTING

##### 4.1 *Operational Improvements to Enhance Current Data Quality and Reporting*

1. Improve the program matching criteria within RM&R as the current criteria do not accurately reflect the rehab/CCC program options that are available. A recent audit of the use of the override function<sup>26</sup> by referrers showed that from April 2009 – February 2010, overrides were used for 30% of the referrals (range: 26 – 33%).
2. Conduct a regular data audit and clean-up to optimize the quality and accuracy of the data captured. Since August, approximately 80% of accepted referrals waiting for admission have been waiting for more than 14 days for admission. The technical issue<sup>27</sup> contributing to this has been addressed by the SIMS team and it is expected that the correction will be reflected in the March data report. However, there is another problem inflating the number of referrals in RM&R, which requires attention. A more efficient method for cancelling referrals of patients who return to facilities outside of RM&R is also required as the current method, which is solely dependent on follow-up by acute care, is not reliable. It is recommended that this issue be explored with users of the RM&R system to determine the best method of addressing the cancellation of referrals in these situations.

In the current RM&R system, if a patient is repatriated to a hospital outside of the RM&R system to await admission to a rehab/CCC facility within RM&R and possibly elsewhere, his/her referrals will remain in the RM&R system as “*accepted and waiting*” until the patient is admitted to an RM&R rehab/CCC hospital. If the patient goes to a non-RM&R facility or decides to forego inpatient rehab, the RM&R system requires that acute care cancel the RM&R referral. Given the high rate of patient turnover on an acute care unit, acute care does not have the resources to track patients once they are discharged from their unit to determine if they have been admitted to rehab/CCC as originally planned. It is likely that this situation contributes considerably to inflating the number of referrals accepted and waiting. A more efficient method for cancelling referrals of patients who return to facilities outside of RM&R is required to reduce or eliminate the reliance on acute care to cancel referrals for patients discharged from their units.

Until these improvements as well as an audit to identify and clean up inactive referrals are implemented, the quality of the data and its analysis are compromised. We cannot differentiate how many referrals are waiting due to technical and process issues versus capacity issues. Once the audit is completed *and* enhancements to the functionality of RM&R are incorporated (See 4 below), the identification of capacity-related issues can be further elucidated.

3. Improve educational tools pertaining to the RM&R system for new and current users. This would involve updating the existing E-learning modules to include instructions on the proper use of the Send Back function. Given that users do not always use the RM&R system as it was intended and required steps are sometimes omitted, updating of the existing Quick User Guide specifically highlighting these circumstances is recommended. Stakeholders have also requested the development of an on-line training module that uses a “dummy referral”, to ensure that all users are utilizing the system correctly and that the quality of the data entered by users is at a high standard.
4. Enhance the functionality of the RM&R system to: (i) increase the speed at which it is able to respond to the needs of users; and (ii) improve the presentation of referral information on the dashboard of each organization. Stakeholders have reported that the RM&R system is very slow for reviewing and responding to referrals, which is contributing to referrers bypassing the system to process referrals via telephone consultation instead. As a result, the Send Back function is bypassed for obtaining updates and the response loop is not closed through RM&R. Furthermore, referrals are not automatically prioritized by date on organizations’ dashboards and are not differentiated according to type of referral (i.e. rehab vs. CCC). As a result, a manual

<sup>26</sup> The override function is used by a referrer when she/he wants to send the referral to a program that is different from the one(s) identified by the RM&R system.

<sup>27</sup> A technical problem with the referral application has been discovered subsequent to the release of the December report. Extraneous referrals for clients admitted have not been automatically cancelled and removed from the count.

audit by users is required to sort through the referrals that have been received. In addition, the system does not include a proper notification system to indicate that an update to a referral has been sent.

#### **4.2 System Improvements to Enhance Data Reporting**

1. Include reasons for why referrals wait once accepted by program category (i.e. HTSD, LTLT and CCC), population and organization in the RM&R system. Information on why referrals are being waitlisted can be used to determine where and what type of additional resources are needed to increase timely access to rehab/CCC and improve patient flow.
2. Provide reasons for denial within each program category by population and organization to pinpoint where denial rates are high and why.
3. Include admissions by home LHIN, currently not available, to illustrate the number of clients who live within and outside of the TC LHIN who receive rehab/CCC from TC LHIN organizations.

#### **4.3 Strategies to Enhance Use of the RM&R Tool to Support System Planning and Improvement**

The GTA Rehab Network has been involved in the review and analysis of the monthly RM&R reports and has participated in several SIMS committees addressing the operational aspects of the RM&R system. Although the Network has regularly shared its work with members of its Patient Access and Flow Committee, the CEOs of the rehab hospitals have expressed interest in formalized discussions about the use of the RM&R tool to inform system planning and improvement. In absence of such a formal communication structure, there is no opportunity at this senior level to examine the data findings, consider the implications of the findings for patient flow and perhaps more importantly, to review the strategic use of the large-scale RM&R electronic referral application to ensure that it is used in a meaningful way to optimize patient flow and system performance outcomes.

### **5.0 FINAL RECOMMENDATION**

The GTA Rehab Network, with its own strategic priorities to continually improve the quality of and access to rehabilitation services, recommends its continued involvement in reviewing the monthly RM&R reports following the March 31<sup>st</sup> closing of its project charter with the Toronto Central. The GTA Rehab Network has demonstrated that it brings to the table many skills and assets to achieve the deliverables of this current project and other initiatives in future. These include the following:

1. Through its analysis of the monthly RM&R reports, the Network has made several contributions to improving the quality and reporting of data in the electronic referral system. This has included recommendations for improving the parameters in the RM&R reporting template to garner the most relevant and focused referral/client information for identifying referral inefficiencies, access barriers and gaps in services. It has also included the identification of process issues on the user side and technical issues on the application side to improve and focus the data reported and the interpretation of the data findings.
2. In reviewing the RM&R data reports, one of the significant contributions of the Network has been its use of both an analytical *and* clinical perspective in its review of the data. This 'clinical filter,' grounded in the Network's detailed knowledge and practical experience with the referral process and the medical complexities of patients, is essential for reviewing the data, identifying discrepancies in the data and using the information to identify system improvements to support patient flow and the ER/ALC priorities across the system.
3. The Network, with its collective voice for all of its member organizations across the continuum – acute care, rehab/CCC, community and beyond the TC LHIN boundaries – ensures that RM&R data is examined from a systems-wide focus rather than from organizational-specific perspectives and accountabilities alone. While these accountabilities are important, addressing barriers to patient flow and access must also include an understanding of and attention to the cumulative effect of forces across the system affecting patient flow. It also requires a commitment from organizations to work together to develop system-wide solutions.

4. The reach of the Network membership extends beyond the SIMS partners within as well as outside of Toronto and as a result, collaborative efforts are strengthened by the inclusion of all voices.
5. The Network has established a reputation for effective stakeholder engagement and for taking leadership in implementing actionable solutions, which are essential components for developing effective, system-wide strategies to enhance patient flow.

Ongoing involvement of the GTA Rehab Network in the analysis of the RM&R reports would enable it to continue its contribution to the work of the Toronto Central LHIN and its priorities to reduce emergency room (ER) wait times and reduce alternate level of care (ALC) days. It would ensure a system-wide focus on the analysis and use of the referral information to identify solutions for improving patient flow, optimizing access, identifying service gaps and addressing capacity questions in rehabilitation and CCC. This recommendation is supported by members of the Network's Patient Access and Flow Committee, representing 15 organizations across acute care, rehab and CCC and the Toronto Central CCAC.

## **6.0 CONCLUSION**

The GTA Rehab Network brings together stakeholders from acute care teaching and community hospitals, rehabilitation and complex continuing care hospitals and Community Care Access Centres across the GTA. Since its inception in 1999, the Network has been working collaboratively with its members to improve patient flow; implement leading practices; respond effectively to the increased medical complexity of patients; and to advance system-wide planning.

More recently, the Network has been fortunate to work with the Toronto Central LHIN and with its support lead initiatives to enhance patient flow for rehab and complex continuing care. This report has focused on the Network's responsibilities within this collaboration to analyze data from the Toronto Central LHIN's Resource Matching and Referral System (RM&R); to monitor performance, capacity and gaps; to identify and develop policies and practices to improve patient flow; and to engage stakeholders in system-wide discussions to assist system planning. The RM&R system is in a relatively early stage in its evolution as a large-scale electronic application and as such, the recommendations that are put forth in this report are done so in the spirit of enhancing the quality of the data captured and the system's capacity to provide meaningful information on patient flow to inform ongoing system-wide improvements. The GTA Rehab Network welcomes the opportunity to continue its collaboration on this and future initiatives with the Toronto Central LHIN.

## 7.0 APPENDICES

## APPENDIX A: RECOMMENDATIONS FOR CHANGES TO RM&amp;R TO IMPROVE DATA REPORTING

GTA Rehab Network Recommended Changes to RM&R to Improve Data Reporting		
Date of Recommendation	Recommendation	Implemented?
Spring 2009	Capture Wait Time by <ul style="list-style-type: none"> <li>▶ Time periods</li> <li>▶ Program Type</li> <li>▶ Population</li> <li>▶ Median</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> <li>✓</li> <li>x</li> </ul>
	Capture Response Time by <ul style="list-style-type: none"> <li>▶ Receiving Org</li> <li>▶ Time periods</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> </ul> Only average reported
	Capture Referral Volume by <ul style="list-style-type: none"> <li>▶ Program type</li> <li>▶ Population type</li> <li>▶ Numbers on weekends</li> <li>▶ Clients admitted on weekends</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> <li>x</li> <li>x</li> </ul>
	Capture Pending referrals by <ul style="list-style-type: none"> <li>▶ Receiving organization</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> </ul>
	Capture Number of Clients by <ul style="list-style-type: none"> <li>▶ Age &amp; Gender</li> <li>▶ Sending organization</li> <li>▶ Program type</li> <li>▶ Population type</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> </ul> For admitted clients only For admitted clients only
	Capture Reasons for Denial by <ul style="list-style-type: none"> <li>▶ Comprehensive list of reasons</li> <li>▶ Program type</li> <li>▶ Population type</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> <li>x</li> </ul>
	Capture Reasons for Waiting	x
	Capture Clients Declined by all programs <ul style="list-style-type: none"> <li>▶ Number of clients</li> <li>▶ Reasons for denial</li> <li>▶ Program type</li> <li>▶ Population type</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> <li>✓</li> <li>x</li> </ul>
	Capture Special Care Need Requests by <ul style="list-style-type: none"> <li>▶ Program type</li> <li>▶ Population type</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>x</li> </ul>
	Capture Number of Referrals Accepted and Waiting by <ul style="list-style-type: none"> <li>▶ Program type</li> <li>▶ Population type</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> </ul>
Summer 2009	Capture Infection Control Issues	✓
Fall 2009	Suggestions to improve clarity in data reports. Include: <ul style="list-style-type: none"> <li>▶ Definitions for how calculations are made including parameters for referrals that counted in calculation</li> <li>▶ Definition of YTD</li> <li>▶ Specify all populations not included in RM&amp;R</li> <li>▶ Recommended wording changes to increase clarity in titles (e.g. Pending referrals; Send Back referrals) and other definitions</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> <li>✓</li> <li>✓</li> </ul>
	For Response Times include: <ul style="list-style-type: none"> <li>▶ Responses to referrals that were submitted prior to the reporting period</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> </ul>
Fall 2009/Winter 2010	Investigate high numbers of Accepted and Waiting referrals	x

**APPENDIX B: MANUAL AUDIT OF DENIED REFERRALS FOR CLIENTS WHOSE REFERRALS WERE ALL DENIED**

Counts the number of referrals for clients with all referrals denied (by each facility) by program and population type from start of RM&R reporting (Feb. 2008) to Feb 2010. Clients with a re-direct or send-back denied reason have been excluded from this analysis.  
 HTSD Other: Includes "Other" and "Rehab High Tolerance/Regular Stream"  
 LTLD Other: Includes "Rehab LTLD/Slow Stream"

		#Denied Referrals for Clients Whose Referrals Were All Denied							
Population		Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	TOTAL
CCC	Complex Medical Services	0	0	0	0	1	1	1	3
	Dialysis Services	0	1	0	1	1	0	0	3
	General CCC Services	0	1	3	1	0	0	1	6
	Neuro Complex Care	0	0	0	0	0	0	0	0
	Palliative Care	0	0	0	0	0	0	0	0
	CCC - Other	0	0	0	1	0	0	0	1
	<b>Total for CCC</b>	<b>0</b>	<b>2</b>	<b>3</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>13</b>
HTSD	Active Neuro	0	0	0	0	0	2	3	5
	Amputee	0	0	1	0	0	2	0	3
	Cardiac	0	0	0	0	0	0	0	0
	General / Medical	1	0	0	0	0	0	0	1
	Geriatric Rehab	1	0	0	2	1	0	2	6
	MSK	1	1	2	1	0	0	4	9
	Respiratory Rehab	0	0	0	0	0	0	0	0
	HTSD - Other	1	2	4	1	3	1	3	15
<b>Total for HTSD</b>	<b>4</b>	<b>3</b>	<b>7</b>	<b>4</b>	<b>4</b>	<b>5</b>	<b>12</b>	<b>39</b>	
LTLD	General	0	0	0	1	0	2	0	3
	Geriatric Slow Stream	1	1	0	0	0	2	0	4
	Neuro	1	0	0	0	0	1	3	5
	Transitional	0	0	0	1	0	0	0	1
	LTLD - Other	0	0	0	0	1	0	0	1
<b>Total for LTLD</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>5</b>	<b>3</b>	<b>14</b>	
<b>Total for all Rehab/CCC</b>		<b>6</b>	<b>6</b>	<b>10</b>	<b>9</b>	<b>7</b>	<b>11</b>	<b>17</b>	<b>66</b>



**APPENDIX C: MANUAL AUDIT OF DENIED REFERRALS FOR CLIENTS WITH ALL REFERRALS DENIED: Medical Needs Cannot Be Accommodated - Other**

		#Denied Referrals for Clients Whose Referrals Were All Denied By Denial Reason: 'Medical Needs Cannot Be Accommodated - Other (Specify)'							
Population		Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	TOTAL
CCC	Complex Medical Services	0	0	0	0	0	0	0	0
	Dialysis Services	0	0	0	0	0	0	0	0
	General CCC Services	0	0	1	0	0	0	0	1
	Neuro Complex Care	0	0	0	0	0	0	0	0
	Palliative Care	0	0	0	0	0	0	0	0
	CCC - Other	0	0	0	0	0	0	0	0
	<i>Total for CCC</i>	<i>0</i>	<i>0</i>	<i>1</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>
HTSD	Active Neuro	0	0	0	0	0	2	1	3
	Amputee	0	0	0	0	0	1	0	1
	Cardiac	0	0	0	0	0	0	0	0
	General / Medical	0	0	0	0	0	0	0	0
	Geriatric Rehab	0	0	0	0	0	0	0	0
	MSK	0	1	0	1	0	0	0	2
	Respiratory Rehab	0	0	0	0	0	0	0	0
	HTSD - Other	0	1	0	0	1	0	0	2
<i>Total for HTSD</i>	<i>0</i>	<i>2</i>	<i>0</i>	<i>1</i>	<i>1</i>	<i>3</i>	<i>1</i>	<i>8</i>	
LTLD	General	0	0	0	0	0	1	0	1
	Geriatric Slow Stream	0	1	0	0	0	1	0	2
	Neuro	0	0	0	0	0	0	0	0
	Transitional	0	0	0	1	0	0	0	1
	LTLD - Other	0	0	0	0	0	0	0	0
<i>Total for LTLD</i>	<i>0</i>	<i>1</i>	<i>0</i>	<i>1</i>	<i>0</i>	<i>2</i>	<i>0</i>	<i>4</i>	
<i>Total for all Rehab/CCC</i>		<i>0</i>	<i>3</i>	<i>1</i>	<i>2</i>	<i>1</i>	<i>5</i>	<i>1</i>	<i>13</i>

**APPENDIX D: MANUAL AUDIT OF DENIED REFERRALS FOR CLIENTS WITH ALL REFERRALS DENIED: Comments for Medical Needs Cannot Be Accommodated – Other**

Counts the number of referrals for clients with all referrals denied (by each facility) by program and population type from start of RM&R reporting (Feb. 2008) to Feb 2010. Clients with a re-direct or send-back denied reason have been excluded from this analysis.  
 HTSD Other: Includes "Other" and "Rehab High Tolerance/Regular Stream"  
 LTLTD Other: Includes "Rehab LTLTD/Slow Stream"

#Denied Referrals for Clients Whose Referrals Were All Denied By Denial Reason and Denial Comments: 'Medical Needs Cannot Be Accommodated - Other (Specify)'																
Population	Aug-09	Aug-09 Denial Comment	Sep-09	Sept-09 Denial Comment	Oct-09	Oct-09 Denial Comment	Nov-09	Nov-09 Denial Comment	Dec-09	Dec-09 Denial Comment	Jan-10	Jan-10 Denial Comment	Feb-10	Feb-10 Denial Comment	TOTAL	
CCC	Complex Medical Services	0	-	0	-	0	-	0	-	0	-	0	-	0	0	
	Dialysis Services	0	-	0	-	0	-	0	-	0	-	0	-	0	0	
	General CCC Services	0	-	0	-	1	Hypodermiyacl ysis is not a long-term hydration strategy (usually only used for a few days)	0	-	0	-	0	-	0	1	
	Neuro Complex Care	0	-	0	-	0	-	0	-	0	-	0	-	0	0	
	Palliative Care	0	-	0	-	0	-	0	-	0	-	0	-	0	0	
	CCC - Other	0	-	0	-	0	-	0	-	0	-	0	-	0	0	
	<b>Total for CCC</b>	<b>0</b>	<b>-</b>	<b>0</b>	<b>-</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>-</b>	<b>0</b>	<b>-</b>	<b>0</b>	<b>-</b>	<b>0</b>	<b>-</b>	<b>1</b>
HTSD	Active Neuro	0	-	0	-	0	-	0	-	0	-	2	(1) Age criteria (2) Does Not Meet Admission Criteria	1	Patient needs ABI program	3
	Amputee	0	-	0	-	0	-	0	-	0	-	1	Slow stream already had the application	0	-	1
	Cardiac	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0
	General /	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0

#Denied Referrals for Clients Whose Referrals Were All Denied By Denial Reason and Denial Comments:  
'Medical Needs Cannot Be Accommodated - Other (Specify)'

Population	Aug-09	Aug-09 Denial Comment	Sep-09	Sept-09 Denial Comment	Oct-09	Oct-09 Denial Comment	Nov-09	Nov-09 Denial Comment	Dec-09	Dec-09 Denial Comment	Jan-10	Jan-10 Denial Comment	Feb-10	Feb-10 Denial Comment	TOTAL	
Medical																
Geriatric Rehab	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	
MSK	0	-	1	More appropriate for Amps but patient decided to go home with out rehab	0	-	1	Diagnosis of patient does not match any of our programs. In addition we cannot accommodate hemodialysis	0	-	0	-	0	-	2	
Respiratory Rehab	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	
HTSD - Other	0	-	1	Patient not appropriate for rehab programs at providence, suggest oncology rehab	0	-	0	-	1	Application sent to Oncology Program	0	-	0	-	2	
<b>Total for HTSD</b>	<b>0</b>	<b>-</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>-</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>8</b>	
LTLD	General	0	-	0	-	0	-	0	-	0	-	1	Declined-failure to cope, needs ++ assistance likely needs 24 hour care or LTC	0	-	1
	Geriatric Slow Stream	0	-	1	Not appropriate	0	-	0	-	0	-	1	Unable to accommodate at this time	0	-	2
	Neuro	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0

#Denied Referrals for Clients Whose Referrals Were All Denied By Denial Reason and Denial Comments:  
'Medical Needs Cannot Be Accommodated - Other (Specify)'

Population	Aug-09	Aug-09 Denial Comment	Sep-09	Sept-09 Denial Comment	Oct-09	Oct-09 Denial Comment	Nov-09	Nov-09 Denial Comment	Dec-09	Dec-09 Denial Comment	Jan-10	Jan-10 Denial Comment	Feb-10	Feb-10 Denial Comment	TOTAL
Transitional	0	-	0	-	0	-	1	Requires LTC placement Providence transition unit at capacity	0	-	0	-	0	-	1
LTLT - Other	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0
<i>Total for LTLT</i>	0	-	1	1	0	-	1	1	0	0	2	2	0	-	4
<i>Total for all Rehab/CCC</i>	0	-	3	3	1	1	2	2	1	1	5	5	1	1	13

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**Resource Matching and Referral Program response to the GTA Rehab Network Report - *Enhancing Access and Patient Flow for Rehab and CCC to Support ER/ALC Priorities***

**Introduction**

This addendum is written to supplement the report submitted to the Toronto Central LHIN (TC LHIN) issued by GTA Rehab Network in April 2010, “Enhancing Access and Patient Flow for Rehab and CCC to Support ER/ALC Priorities.” The primary purpose of this document is to provide insight from a TC LHIN RM&R Program perspective – with respect to the information technology (IT) aspects of the RM&R program, in order to provide an accurate status of the recommendations outlined in the report. Additional suggestions and action items pertaining to the GTA Rehab Network’s recommendations have also been addressed. Any recommendations or findings around processes or policies that are not IT related have not been addressed in this addendum.

<b>DELIVERABLE: Implementation of an Approach to Manage the Ongoing Review of RM&amp;R</b>	
<b>Recommendation:</b> Include referral data by population type (e.g. MSK, Cardiac etc.), gender and age categories in addition to tracking the number of referrals submitted by and to organizations.	<b>Status:</b> <ul style="list-style-type: none"> <li>• Referral information by organization available</li> <li>• Referral information by existing program listing in RM&amp;R available. The enhancement request to update program listings and matching has been submitted to the Program team for scoping and prioritization.</li> <li>• Referral data is currently available by age and gender by site, but not population. This has been logged as an enhancement request. Recommended process would be to include RUG and RAAC.</li> </ul>
<b>Recommendation:</b> Include referral data by response time categories (e.g. number of referrals with response < 2 days, 3-5 days etc.), average response time, program type, population type and receiving organization.	<b>Status:</b> <ul style="list-style-type: none"> <li>• Average response time (RT) by program type and RT by organization are available</li> <li>• RT categories have been reported for other reports (pending, accepted but waiting) as identified during first report development.</li> <li>• Average RT by population has been implemented for populations identified previously during first report development.</li> <li>• A request has been logged to update populations and programs reported.</li> </ul>
<b>Recommendation:</b> Include referrals that were submitted outside of the reporting period	<b>Status:</b> <ul style="list-style-type: none"> <li>• Implemented</li> </ul>
<b>Recommendation:</b> Include a “Send Back” function to enable tracking of referrals that have been responded to by the receiving organization, but are “pending” because additional information is required.	<b>Status:</b> <ul style="list-style-type: none"> <li>• Implemented. RM&amp;R Working Group previously identified this as a high priority enhancement. Was prioritized in March 2009 by BLF and implemented in August 2009.</li> </ul>

**Resource Matching and Referral Program response to the GTA Rehab Network Report - *Enhancing Access and Patient Flow for Rehab and CCC to Support ER/ALC Priorities***

<p><b>Recommendation:</b> Include data for each program type and population.</p>	<p><b>Status:</b></p> <ul style="list-style-type: none"> <li>• Data available by program type</li> <li>• Data available by population as currently available in RM&amp;R. This is in the report by category and population (report 2.6).</li> <li>• As above, a request has been logged to update populations and programs reported.</li> </ul>
<p><b>Recommendation:</b> Include reasons for waiting.</p>	<p><b>Status:</b></p> <ul style="list-style-type: none"> <li>• Documented on enhancement log for prioritization by RUG and BLF.</li> </ul>
<p><b>Recommendation:</b></p> <ul style="list-style-type: none"> <li>• Track wait times by population</li> <li>• Track median wait times</li> </ul>	<p><b>Status:</b></p> <ul style="list-style-type: none"> <li>• Wait times are reported by current population and program types.</li> <li>• Median wait time is not currently reported. This has been logged as an enhancement request.</li> </ul>
<p><b>Recommendation:</b> Revise the start time for tracking wait time from the date patient is rehab ready to the date that the referral is sent.</p>	<p><b>Status:</b></p> <ul style="list-style-type: none"> <li>• Require further information. Date client is rehab ready is not reported on. Currently, Wait time = date of acceptance to date of admit.</li> <li>• At PAF there have been discussions around including Total Wait time = date sent to date of admit. This would include Response Time and current Wait Time to provide a full picture of client wait time. This has been logged as an enhancement request.</li> </ul>
<p><b>Recommendation:</b> Include a comprehensive list of reasons for denials. Identify number of referrals and clients for whom all referrals were denied by program type, population type and organization.</p>	<p><b>Status:</b></p> <ul style="list-style-type: none"> <li>• Implemented. RM&amp;R Working Group previously identified this as a high priority enhancement. Implemented in August 2009.</li> <li>• Clients with all referrals denied is currently reported on for special population groups as identified during report development. As above, a request has been logged to update populations and programs reported.</li> <li>• Require further information regarding denial by organization and population. Capability exists to report by organization and population, however it is unclear if this request is to implement organization and population specific reasons. The latter would require significant development and would decrease standardization for reporting.</li> </ul>
<p><b>Other</b></p>	
<p><b>Recommendation:</b> Improve the program matching criteria within RM&amp;R as the current criteria do not accurately reflect the rehab/CCC</p>	<p><b>Status:</b></p> <ul style="list-style-type: none"> <li>• The enhancement request to update program listings and matching</li> </ul>

**Resource Matching and Referral Program response to the GTA Rehab Network Report - *Enhancing Access and Patient Flow for Rehab and CCC to Support ER/ALC Priorities***

<p>program options that are available</p>	<p>has been submitted to the Program team for scoping and prioritization.</p>
<p><b>Recommendation:</b> Conduct a regular data audit and clean-up to optimize the quality and accuracy of the data captured. a) A more efficient method for cancelling referrals of patients who return to facilities outside of RM&amp;R is also required as the current method, which is solely dependent on follow-up by acute care, is not reliable</p>	<p><b>Status:</b></p> <ul style="list-style-type: none"> <li>• Management of out of LHIN referrals (i.e. repatriation) as been added to enhancement log for RUG discussion.</li> <li>• The technical issue noted is resolved – go forward and historical data. The go forward fix was implemented late February 2010 and the historical clean up was completed by April 2<sup>nd</sup> 2010.</li> <li>• The requirements for a regular data audit will be further discussed at RAAC.</li> </ul>
<p><b>Recommendation:</b> Improve educational tools pertaining to the RM&amp;R system for new and current users.</p>	<p><b>Status:</b></p> <ul style="list-style-type: none"> <li>• The RM&amp;R Program and the vendor are currently investigating further expansion of the current eLearning tools available to support training on the application. There is continued focus on exploring other avenues of further education on using the system.</li> </ul>
<p><b>Recommendation:</b> Enhance the functionality of the RM&amp;R system to increase the speed at which it is able to respond to the needs of users</p>	<p><b>Status:</b></p> <ul style="list-style-type: none"> <li>• In the past 6 months, the vendor has confirmed an improvement of 40-60% on application page load times. Further work is required to streamline receiving process, and the RM&amp;R Problem Management team is continuing to investigate other areas within the infrastructure that could be lead to further performance improvements</li> </ul>
<p><b>Recommendation:</b> Enhance the functionality of the RM&amp;R system to improve the presentation of referral information on the dashboard of each organization</p>	<p><b>Status:</b></p> <ul style="list-style-type: none"> <li>• The service provider queue will be enhanced with LTC Bed Level Matching. The mock ups reflecting enhancements will be reviewed by the RM&amp;R User Group on May 13<sup>th</sup>, 2010, for implementation in late fall/early winter 2010.</li> </ul>
<p><b>Recommendation:</b> Include admissions by home LHIN, currently not available, to illustrate the number of clients who live within and outside of the TC LHIN who receive rehab/CCC from TC LHIN organizations</p>	<p><b>Status:</b></p> <ul style="list-style-type: none"> <li>• Added to enhancement log for prioritization by RUG and IBLF.</li> </ul>