TRANSFER OF REHABILITATIVE CARE

In the Mississauga Halton LHIN

Fall 2019 PILOT

"A rehabilitative care approach to seamless transitions across the care continuum…keeping the patient experience in mind"

PROVIDER IMPLEMENTATION TOOLKIT

October, 2019

Ontario

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TRANSFER OF REHABILITATIVE CARE

1.0 Project Overview

The current rehab referral environment is very fragmented, where information does not always follow the patient as they transition across the rehab care continuum to meet their rehab goals. There is currently no common standard for sharing consistent information about a patient's rehab/medical history and progress on rehab goals with other rehab providers in the community. In addition, each referring therapist has to look through organization specific referral forms when making a referral to outpatient and community rehab programs within the Mississauga Halton LHIN. This takes administrative time to complete the various referral forms and is not always efficient. There is an obvious information gap in our current rehab referral environment for outpatient and community rehab programs, which is causing:

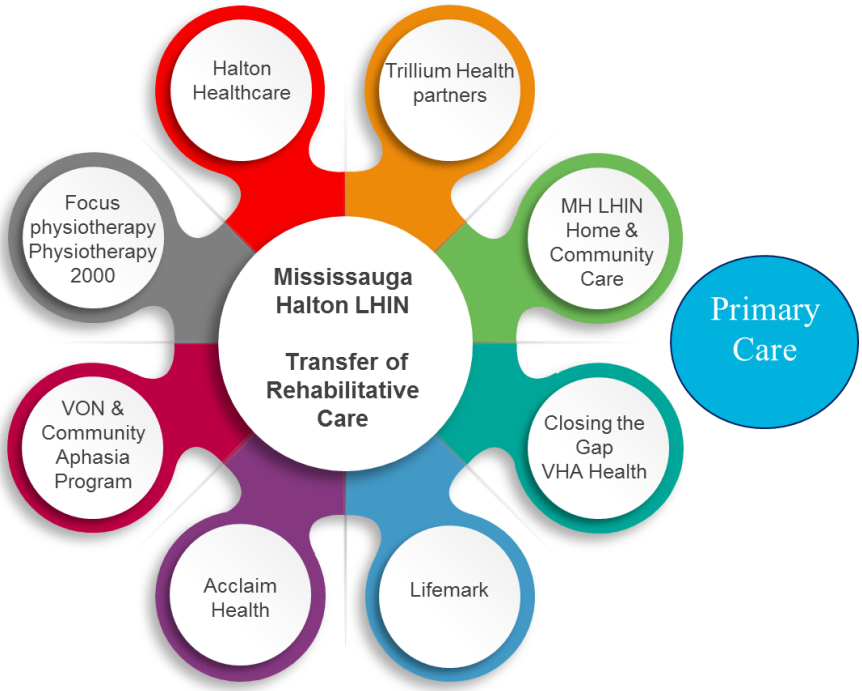
- Delays in patients being seen by community therapists, having to chase the right rehab information from the sender on patients being referred to programs
- Patients having to repeat their story twice, since the right information does not follow the patient. Often leaving patients with a negative experience and frustrated.

That's where the Transfer of Rehabilitative Care (TRC) project comes in. The TRC is a Mississauga Halton (MH) LHIN Initiative to streamline & standardize the amount and type of information shared with rehab providers as patients transition through the continuum of care to achieve their rehab goals. The TRC form:

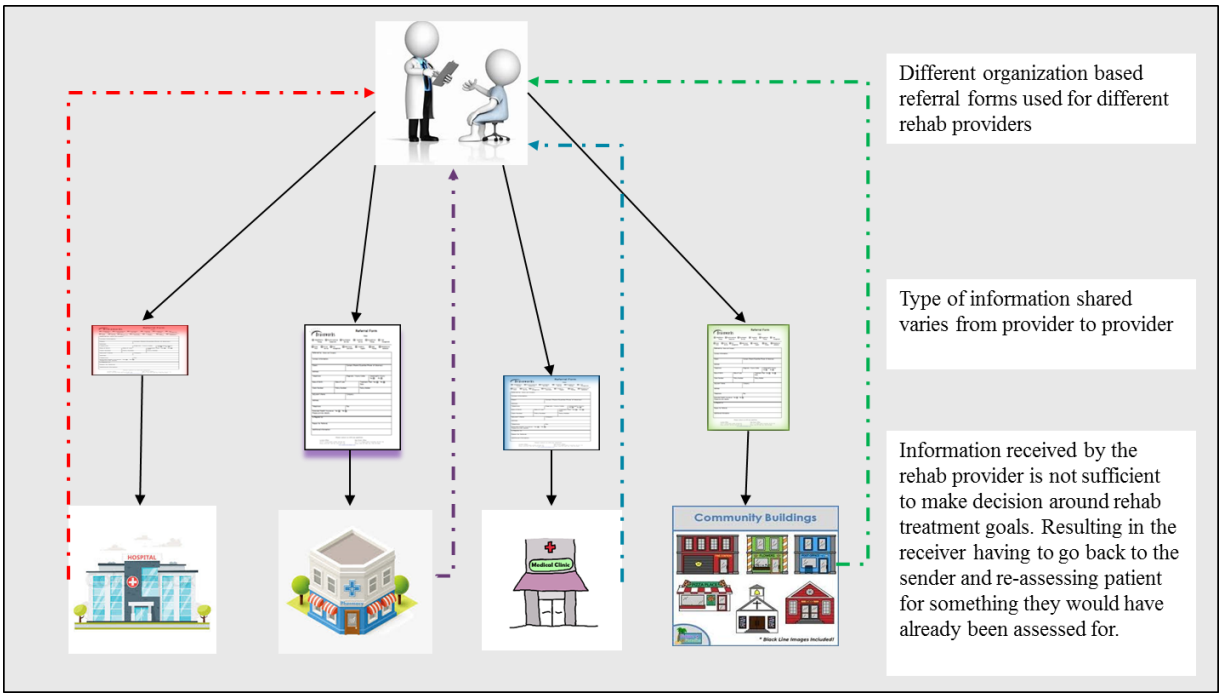
- Represents one common form to be used for making referrals to all outpatient, home care and community rehab programs supported by allied staff and funded through the Ministry or MH LHIN.
- A TRC form is completed and shared with other rehab providers in the community, if client rehab goals at the current setting are not met and if client is identified as needing additional rehab in the outpatient and/or community setting.
- TRC form will act as a common rehab goals/referral/discharge document among all rehab care providers involved in maintaining/achieving client goals as the clients transition to various providers
- The TRC form is not to be completed for referrals to bedded level of rehabilitation, programs not supported by allied staff, such as referrals to private therapists in the community.

The Transfer of Rehabilitative Care form was developed through multiple stakeholder engagements and with the support of the Community Rehabilitative Care Planning Committee at the MH LHIN, consisting of hospital and community partners, including:

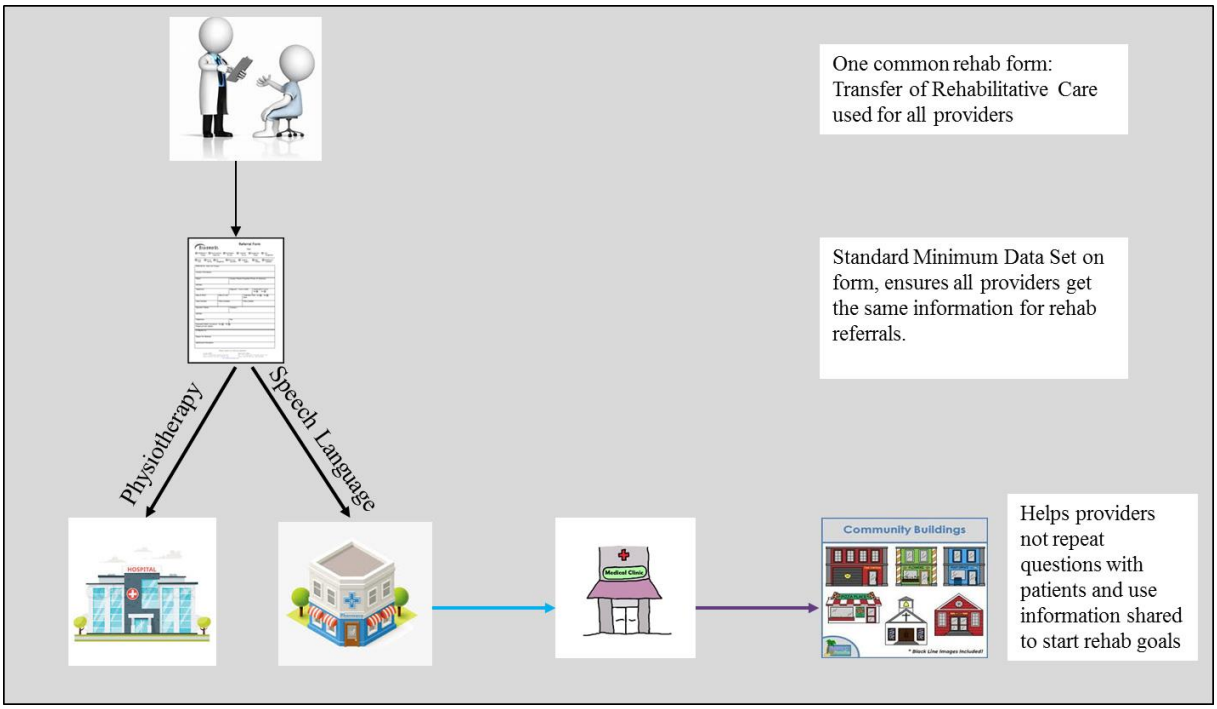
Figure 1:



1.1 The Current Outpatient/Community Referral Landscape



1.2 The Proposed Outpatient/Community Referral Landscape through Using the TRC Form:



2.0 Alignment with Provincial and Regional Priorities:

Seamless transitions to care has been a provincial priority for many years and still continues to be an area of focus with the new government. Health Quality Ontario has worked on developing guidelines for transitions to care, the GTA Rehab Network recently shared their Transfer of Accountability principles, all focusing on ensuring the right and consistent communication tools are in place for providers and patients.

The Transfer of Rehabilitative Care project not only addresses the best practice principles for transitions to care by addressing the information gap between providers, it also ensures that the patient is kept at the center of our planning and does not have to repeat their story twice. The Patients and caregivers have been a strong voice in shaping our project, and have helped co-design a Patient version of the Transfer of Rehabilitative care form to be provided to patients at discharge from a rehab appointment. We continue to take regular updates to our patient and family advisors who were involved in this project and they are very eager to see this project go-live and spread widely.

3.0 Project Goals and Outcomes:

The primary goals of the project are:

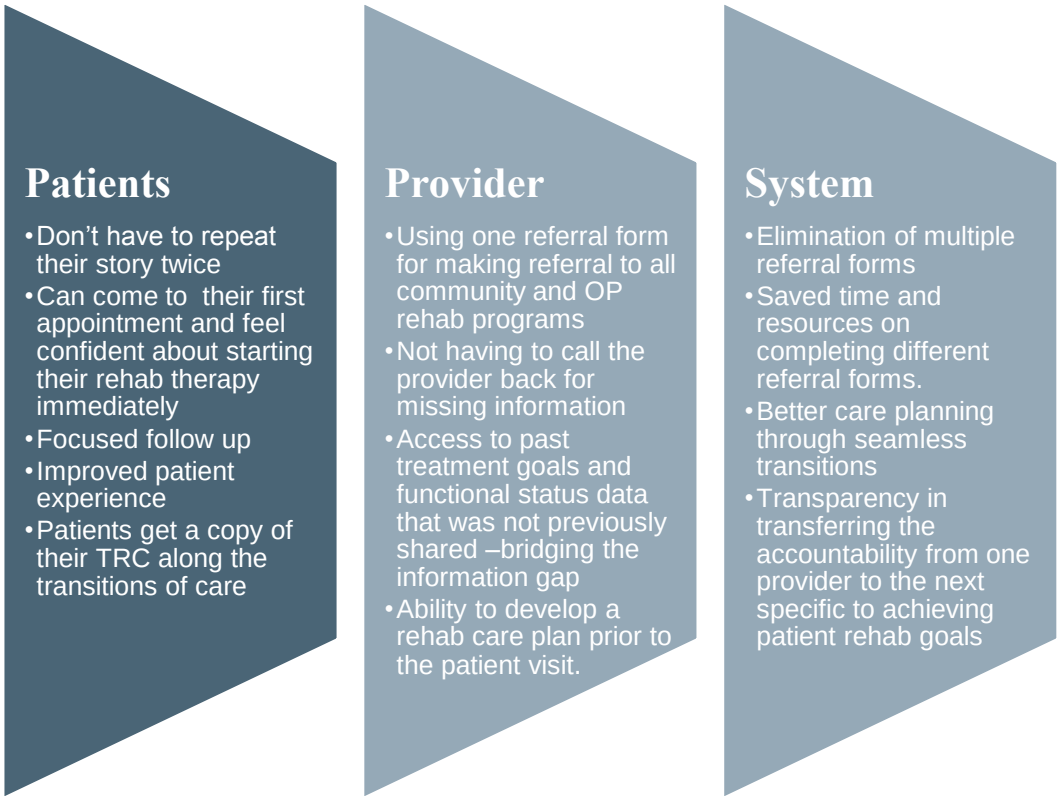
- ✓ To improve communication between referring therapists as patients transition across the continuum of care to meet their rehab goals
- ✓ Replace all existing outpatient (Hospitals) and community rehab referral forms with one common rehab referral form (Transfer of Rehabilitative Care Form) for referrals to all outpatient

and community rehab programs within the Mississauga Halton LHIN, supported by allied staff and funded through the Ministry and/or MH LHIN.

- ✓ Keeping patients at the center of their rehab planning and improving communication between therapists and patients by providing patients with a patient version of the Transfer of Rehabilitative Care form (One page rehab summary) upon discharge from a rehab program

Please see below for projects goals and benefits for the patient, provider and healthcare system.

Figure 2:



4.0 Project Scope:

As mentioned earlier, the following clearly describes the program scope of the project, identifying any inclusion and exclusion criteria for using the TRC form:

Inclusion Criteria:

- Referrals to all rehab outpatient/ambulatory clinics at hospitals, home and community care rehab service provider organizations, community physiotherapy clinics, and community rehab programs, supported by allied staff and funded through the Ministry and/or MH LHIN.
- All rehab populations supported through allied programs in the outpatient/ambulatory clinic in hospitals or through community rehab programs

Exclusion Criteria:

- Outpatient/ambulatory clinics or community rehab programs not supported by allied staff or funded through Ministry or MH LHIN
- Outpatient/ambulatory clinics or community rehab programs outside the MH LHIN boundary.
- OT Pre-Discharge Assessment, at home OT assessment requires minimal visits by the OT and therefore a TRC form does not need to be completed in such instance.
- Private clinics/private therapists in the community
- Community support programs offered through exercise specialists, or non-allied staff such as City of Mississauga, Next steps to Active Living and Fall Prevention and Exercise classes offered through Lifemark Seniors Wellness etc.
- Referrals to bedded level of Rehab, i.e. to Rehab, Complex Continuing Care and Convalescent Care Beds will not be made through a TRC form, the focus of the project is strictly on outpatient/ambulatory, home care and community rehab programs.

5.0 Pilot Scope and Populations:

The fall 2019 pilot will focus on testing the Transfer of Rehabilitative Care form with select Health Service Providers (HSPs) and Service Provider Organizations (SPOs) across the Mississauga Halton LHIN. The form will be tested through various referral channels from Inpatient Rehab units to home and community care and outpatient/community rehab programs, explained later in the toolkit. The objective of the pilot is to help introduce the TRC form in a controlled setting and obtain frontline staff and patient feedback:

- To help address any gaps or areas for improvement in the TRC form and the patient TRC form
- To help address any referral process gaps and areas for improvement for a regional implementation of the TRC form across all rehab providers within MH LHIN.

The fall 2019 pilot for the Transfer of Rehabilitative Care form will focus on the following two patient populations:

- Stroke
- Hip and Knee Bundle Care (Halton Healthcare – Oakville site only)

With bundle care rolling out in FY 2020-21, and with some of the current challenges that we see in processing and sending referrals to our stroke population, it was decided that stroke would be a good test population for the pilot. It also allows for the TRC form to be tested across multiple settings spanning from hospital, to home care, to outpatient rehab and community rehab programs

Hip and Knee Bundle care represents a more streamlined pathway through the Ministry bundle care initiative and allows for an opportunity to test the TRC form for a different population to ensure that the feedback collected through the pilot supports various rehab populations and gives a wholesome picture for any changes to the TRC form, post pilot.

The following organizations will be participating in the fall 2019 pilot to test the Transfer of Rehabilitative Care form for the Stroke Population in a controlled test setting.

Hospitals	MH LHIN Home and Community Care SPOs	Community Rehab Programs
Trillium Health Partners – (Credit Valley Hospital: Unit 1D and Seniors & Rehab Day Hospital) Halton Healthcare – (Oakville Site –to be confirmed)	VHA Closing the Gap CBI Health St. Elizabeth Health	Lifemark – Community Step-Up Halton Peel Community Aphasia Program

A confirmation of the bundled care Hip and Knee pathway in-scope participating sites and the exact units within the Inpatient and outpatient areas for both Stroke and Hip and Knee at Halton Healthcare – Oakville site will be provided prior to the go-live date.

6.0 Health Service Provider Site Champions:

To help support the pilot at a site level, the role for HSP site champions has been created. These site champions are known to their organizations and will serve as a key link to support frontline staff at their organizations throughout the pilot period. In addition HSP site champions will act as a Liaison between the participating site and the project lead. Please see below for the roles and responsibilities of a site champion and a list of the provider site champions including their contact information.

Roles and Responsibilities:

- Oversee project implementation from beginning of pilot until end, this means 6 months of the pilot and post pilot evaluation (1 month).
- Act as the project representative or main lead for the Organization, and act as a point of contact for other teams and departments within the HSP. For example within Halton Healthcare – Oakville site, act as the point of contact and liaison for Inpatient Acute, Inpatient Rehab and Outpatient/Ambulatory care teams. For Home and Community Care Service Provider Organization, act as the main contact and liaison for all rehab front line staff (managers and frontline) that will be participating in the pilot.
- Act as the point of contact to communicate project updates to senior team within your respective organizations.
- Attend all calls or meetings with the project team for Transfer of Rehabilitative care, led by Amy Khan at the Mississauga Halton LHIN.
- Champion the project within your respective organizations and be the change agent to educate and support staff through the pilot with the support of the project team.
- Share information provided by the TRC project team with front line staff
- Respond to any questions about the TRC project that can be managed or addressed at the organization level specific to accommodating HSP operations and organization specific processes.

- Share any questions from frontline staff that cannot be addressed at the HSP level with the Project team and work with the project team to ensure a coordinated response is provided back to the front line staff.
- Work with the project team to identify any solutions to any issues/challenges identified during the pilot and help with mitigating and operationalizing any mitigation strategies to address such challenges.
- Act as the main point of contact to ensure Quality checks are in place to ensure that the Transfer of Rehabilitative Care Form is used and implemented as per project guidelines described in the toolkit for the target population.
- Ensure that all required front line staff from all units and departments are trained and educated on how to use the Transfer of Rehabilitative care form and are aware of any local changes to organization specific referral processes internally to accommodate the pilot.
- Communicate to project team that any described project milestones and timelines are on track, including training and education of all impacted staff prior to pilot go-live.
- Project team will develop a project tracking dashboard/report for the 6 months of the pilot, this dashboard will have a line item specific to each participating site/unit, requiring each site champion to provide their organization specific feedback at select times throughout the pilot cycle. Ensure that the project status dashboard/report specific to your organization's section is completed and provided to the project team on time.
- Evaluation surveys (developed via survey monkey) for Health Service Providers will be developed by the project team for a 3 month and 6 month check with all participating HSPs. Ensure that these surveys are completed on time and results provided back to the project team.
- Evaluation surveys for patients will be developed by the project team through a survey monkey link and on a manual paper survey. These surveys are to be provided to patients at their last rehab visit. Ensure that these surveys are administered either on the last patient visit or 1 week post program discharge. All paper survey results are to be stored together and provided to the LHIN at the end of the pilot for the project team to analyze. Hospitals sites are excluded for administering the patient surveys, since they surveys reflect a transition of rehab care between two providers at minimum. Hospitals being the first to start the Transfer of Rehabilitative care process do not fit the scope for the patient survey process.

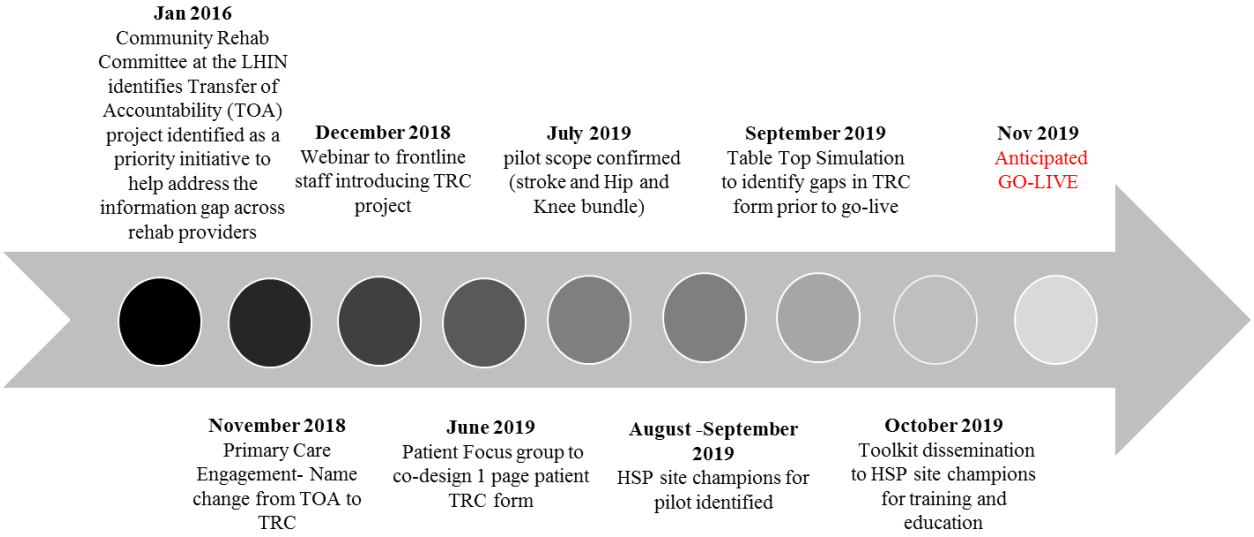
6.1 Health Service Provider Site Champions Contact List

Health Service Provider	Name	Title	Contact Email
MH LHIN	Amy Khan	Project Lead (TRC)	Amy.khan@lhins.on.ca
Trillium Health partners – CVH	Rodger Covey	Patient Care Manager Rehab1D & MED1E	Rodger.Covey@thp.ca
Trillium Health partners – CVH	Betty Vukusic	Rehab Admissions Coordinator	Betty.Vukusic@thp.ca
Trillium Health partners – CVH	Angela Mitrovic	PT, S&RDH	Angela.Mitrovic@thp.ca

Halton Healthcare – Oakville site	Catharine Duncan	Patient Care Manager- IP Allied Health	CDUNCAN@haltonhealthcare.com
VHA	Hira Hajira		hHajira@vha.ca
Closing the Gap	Rohini Telang	Community Services Manager Therapy	Rohini.Telang@closingthegap.ca
CBI Health	Cheryl Wakefield	Therapy Leader	cwakefield@cbi.ca
CBI Health	Rebecca Gani	Speech Language Pathologist	rgani@cbi.ca
St. Elizabeth Health	Rowena Kay Telang	Rehabilitation Services Supervisor	RowenaKayTagle@sehc.com
Lifemark – Community Step Up	Kristy Musialik	Director, Community Partnerships	Kristy.Musialik@Lifemark.ca
Halton Peel Community Aphasia Program	Carly Woods	Speech Language Pathologist	carlywoods@monarchhouse.ca
MH LHIN	Melissa Aldoroty	Manager, Home and Community Care, Rehab and Complex Seniors	melissa.aldoroty@lhins.on.ca

7.0 Pilot Timelines:

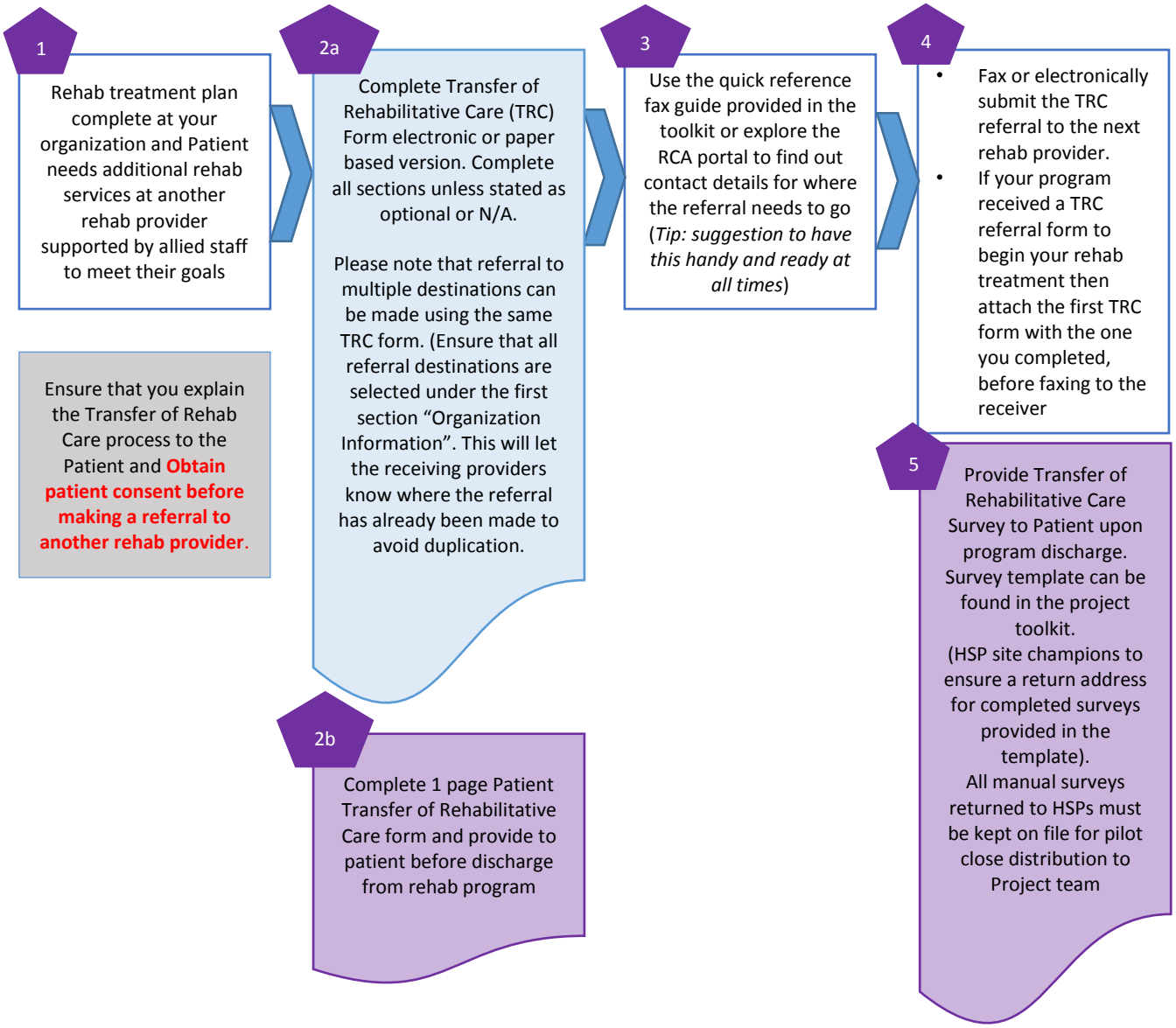
The timelines below shows major milestones and accomplishments for the TRC project. The anticipated **go-live** is scheduled for November **18, 2019**. The Pilot will go until the end of Mar 31, 2020. The duration of the pilot will be 3-4 months, with regular touch points between the project lead and HSP site champions. The pilot will be implemented in a staggered phased in approach, where by sites that are ready to implement will go first with other sites joining in later, once they have checked off the pilot readiness checklist provided in this toolkit. At this point we are looking at all in-scope participating sites to be on schedule for the go-live with the exception of Halton Healthcare – Oakville site having a delayed/staggered start to the implementation.



With the toolkit release in early October, the weeks prior to the go-live will focus on frontline staff training and educating on the TRC project and to ensure internal business processes have been updated to reflect a state of readiness at each participating site. Because of the varying referral environments across the various HSP sites, the implementation readiness around business processes will vary. Therefore the TRC form has been developed in a digital format (pdf fillable form) to be completed on the computer, making it easy to use all drop down and check box options. However, we understand that some therapists do not always have access to a computer and might need to carry paper versions of the TRC form and complete it manually, therefore a paper based manual form has been developed to allow various referring environments to accommodate the TRC form implementation.

8.0 How to Process the Transfer of Rehabilitative Care Form:

Process A: Completing and Sending a Transfer of Rehabilitative Care Form



Things to Remember:

- Ensure client consent is obtained if a TRC referral needs to be completed and that the patient understands that the Transfer of Rehabilitative Care process is being initiated where their rehab information will be shared with the next rehab provider to help them plan ahead to meet the patient's rehab's goals.
- If you received a TRC form and are initiating a second TRC form referral, attach the first one so that the receiver of the referral has the previous history as well. Unless the First TRC referral was already sent to the referring program (check the first TRC form "Organization information" section to get details). This is explained further under scenario 1: Stroke referral below.
- Provide a Patient TRC form to the patient at discharge from the rehab program
- Please ensure Health Service Provider contact details and return address is added to the TRC patient survey template (Appendix B).
- Provide the TRC patient survey to the client at program discharge or within a week of discharge so that the rehab experience is still fresh in their minds.
- Pilot sites will continue to use the TRC form post pilot end with final changes included to the TRC form and business processes as per results of the pilot.

Note to Hospital Teams:

Please ensure that referring allied staff from the Inpatient units (if referral originating from IP) and Outpatient units (If referral originating from Outpatient) are discussing the patient's rehab needs jointly and are noting down their comments for their area on the TRC form. Only one TRC referral is made by the referring therapist from the unit. Likely the last one to see the patient, and it reflects comments from all other allied staff that would have seen the patient prior to discharge.

For referrals to Home and Community Care, Hospital teams must ensure the following documents are submitted together for the TRC process to work effectively:

1. MH LHIN Referral sheet	**2**. TRC Form (including any discharge documents/other attachments to support TRC referral)

Process B: Receiving a Transfer of Rehabilitative Care Form

1. Review the form in its entirety to help prepare for your first patient visit/appointment.
2. Proceed with client rehab treatment and therapy
3. Client is ready to be discharged from program. Assess additional rehab needs.

4a. If no additional rehab needs, TRC form does not need to be completed and process stops.

Complete one page Patient Transfer of Rehabilitative Care form (leave additional rehab referral information blank). Provide to patient before discharge from rehab program

4b. If client needs additional rehab then complete a second TRC form

Complete Steps 1 to 5 under Process A: Completing and sending a TRC form

If you are a receiver at the second transition point you will receive an original TRC form attached with the referral as well showing the first transition point history for the patient. In such instances, please review both TRC forms prior to patient appointment

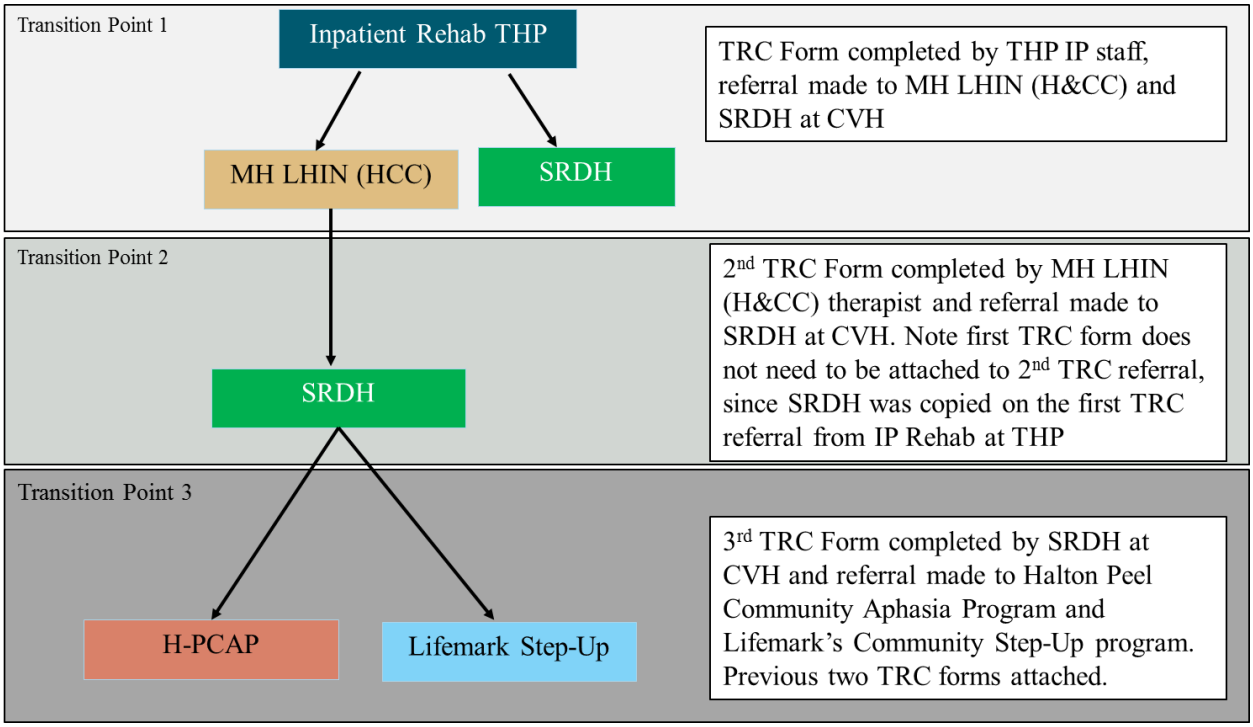
Patient TRC Form

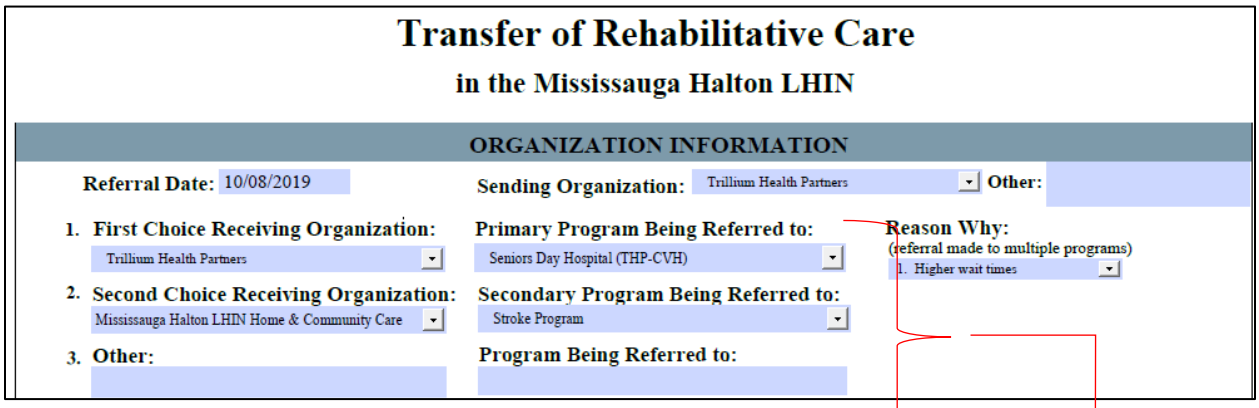
Additional Rehab Needed: Yes ☐ No ☐ **Self-Management/Maintenance** ☐

If yes, please identify referral details related to the next rehab provider

Rehab Referral Made To:
Provider Name: _____ Contact Details: _____

Scenario 1: Stroke Referral for a patient originating from IP Rehab unit at Hospital





Transfer of Rehabilitative Care

in the Mississauga Halton LHIN

ORGANIZATION INFORMATION

Referral Date: 10/08/2019 **Sending Organization:** Trillium Health Partners **Other:**

1. **First Choice Receiving Organization:** Trillium Health Partners — **Primary Program Being Referred to:** Seniors Day Hospital (THP-CVH) — **Reason Why:** (referral made to multiple programs) 1. Higher wait times
2. **Second Choice Receiving Organization:** Mississauga Halton LHIN Home & Community Care — **Secondary Program Being Referred to:** Stroke Program
3. **Other:** — **Program Being Referred to:**

Please note that in this scenario, The First TRC referral is made to Seniors & Rehab Day Hospital (SRDH) at CVH and MH LHIN Home and Community care using the same TRC form.

This lets Home and Community Care SPOs know who the original referral went to, and that there is no need to attach the First TRC form to the 2nd TRC form that will be completed and sent to SRDH at CVH to help avoid duplication.

Please refer to Appendix A to see at how the TRC form will be processed within home and community care through uploading into CHRIS (home and community care data system) by Care Coordinators and Team Assistants to the actual workflow for a TRC referral for our service provider organizations.

9.0 Pilot Evaluation Framework:

As mentioned in the goals and outcomes section earlier, the two main objectives of the project are to:

- Improve communication between therapists as patient's transition across the rehab continuum of care to meet their rehab goals and to avoid having to go back to the sender to obtain patient information essential for patient care planning.
- Improve communication between the therapists and patients upon discharge from rehab appointments resulting in patients having a better understanding of their rehab goals and how to attain them. In addition introducing a process whereby patients do not have to repeat their history/previous rehab information multiple times, resulting in a more focused therapy session between the therapist and patient.

To meet the above mentioned goals, the project pilot will focus on evaluating two main things:

1. Content of the therapist TRC form, if the information in the form helped the rehab providers. If not what can be done to improve the form
2. Content of the patient TRC form and rehab summary process, to evaluate if the patients felt the rehab transitions experience was smooth.

Feedback will be collected through evaluation surveys (online and manual paper based) developed for our two target audiences:

1. Health Service Providers &
2. Patients

9.1 Survey Administration Process:

Surveys have been developed by the TRC project team for Health Services Providers (HSPs) and Patients with the help of our Community Rehab Steering Committee at the LHIN.

HSP Surveys:

HSP surveys will be administered directly from the project lead to HSP site champions. The project lead will develop a survey template through survey monkey and share the survey links twice throughout the project duration as follows:

- **Pilot Mid-point survey**: The survey link will be shared at the 3 month point from the go-live date. The purpose of the pilot mid-point survey is to evaluate any immediate risks or areas of improvement specific to the TRC form and process. The survey results will be evaluated by the project lead and shared with the community rehab steering committee of Mississauga Halton LHIN to recommend a course of action to mitigate any risks flagged or area of opportunity at the

mid-point before proceeding with the remaining duration of the pilot period. Any changes to the TRC form through feedback collected from the HSP site champion surveys will have to be unanimous across participating pilot sites, with a mutual agreement reached for major changes across participating HSP sites. Any proposed changes to the TRC form will be based on the following principles:

  - Presenting a risk to the current business processes resulting in risks and delays impacting day to day operations observed through a consistent time frame during the pilot.
  - Impacting patient care and quality of rehab services received by patients.

- **Project End Final Survey:** The final survey link will be sent to HSP site champions at the end of the pilot period i.e. March 2020. The objectives of the final TRC surveys are similar to the mid-point survey with the opportunity to obtain feedback to develop a regional implementation plan for onboarding all sites across the MH LHIN. In addition making any final changes to the TRC form (HSP and patient version) for use by participating sites beyond the project end timelines.

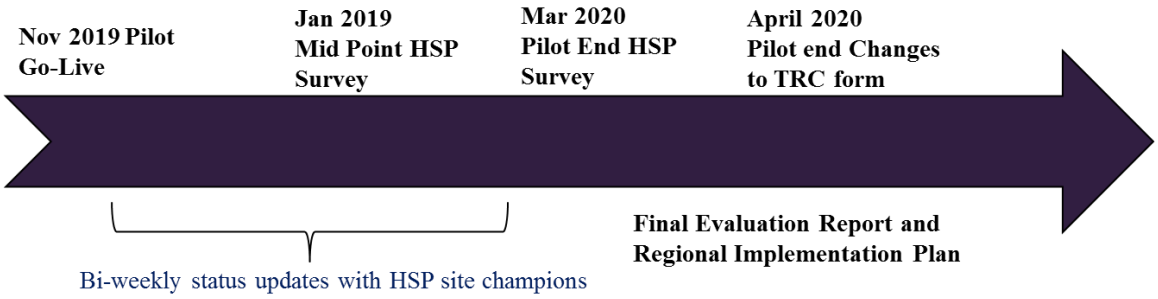
Patient Surveys:

Due to patient privacy concerns the LHIN cannot directly administer patient surveys. Therefore, all participating HSP pilot sites have agreed to administer the patient survey on behalf of the project. Hospital Inpatient areas do not have to administer the patient survey, since most referrals originate from the hospital (Inpatient) where the patients have not experienced a first transition point yet in their rehab journey. Patient surveys must be administered at the last rehab visit for the patient or within a week or so post discharge from a rehab program.

The patient survey has been developed and attached in Appendix B. The survey is developed as a paper based survey, which includes an online survey monkey link allowing patients to complete the survey either online or through the paper based copy. All HSP site champions must ensure that that paper based survey includes a return address and contact for their organization before printing the copies and/or sharing them with frontline therapists. Some HSP sites who conduct phone surveys with their patients upon discharge from rehab program have the flexibility to add the TRC survey questions on their existing telephone survey template. If the patient surveys will be administered through telephone, it is important that staff who are administering the survey read the patient the privacy disclaimer and ensure that they separate the feedback collected on the TRC pilot from any other existing survey questions specific to the HSP's rehab program.

Surveys completed through the online survey monkey link will be submitted directly to the LHIN since they are developed using a LHIN survey monkey account. Surveys that are completed manually on paper and submitted back to the respective HSP pilot sites should be kept safe and filed. These paper surveys will be collected by the LHIN project lead at the end of the pilot for evaluation.

Analyzing completed surveys will be the responsibility of the Project team at the LHIN. Please see below for a high level evaluation timeline including important project review dates.



10.0 GTA Rehab Network Transfer of Accountability Guiding Principles:

The GTA Rehab Network has developed the "Inter-organizational Transfer of Accountability (TOA) Guidelines" to support safe patient care transitions across organizations and sectors by the GTA Rehab Network and members of its hospitals and home and community care working groups. (*GTA Rehab Network's Inter-Organizational Transfer of Accountability guidelines, July 2019 slide deck*)

The Transfer of Accountability guidelines complement Health Quality Ontario's quality standard with two key difference:

Scope: TOA guideline addresses transfer of information and follow-up care and not transition planning

Focus: TOA guideline incorporates a broader focus on transitions from hospital to hospital, hospital to home and community care or outpatient rehab.

The TOA guiding principles developed by the GTA Rehab Network focus on transfer of accountability across the patient lifespan and care continuum. The six guiding principles include:

1. Ensure health service providers understand and have knowledge of legislation and policies that guide effective transitions.
2. Communicate patient and caregiver preferences and goals to the next level of care.
3. Establish one key contact and each transition point.
4. Standardize organizational processes for transition.
5. Communicate effectively among health care providers to facilitate transition.
6. Acknowledge dual responsibility of senders and receivers in transition.

10.1 Alignment with Transfer of Rehabilitative Care and GTA Rehab Network Transfer of Accountability Guiding Principles:

The scope of the Transfer of Rehabilitative Care project is broader unlike the scope for the GTA Rehab Network's Transfer of Accountability initiative, and includes transitions from hospital to outpatient, to home and community care, community physio clinics and other community rehab programs within Mississauga Halton LHIN funded through the Ministry and LHIN and supported by allied staff. Also the GTA Rehab Network Transfer of Accountability initiative focuses on transitions for bedded level of rehab

as well, which is not in scope for the Transfer of Accountability initiative, focusing on outpatient, home care, and community rehabilitative care transitions only.

All six guiding principles are well supported through the Transfer of Rehabilitative Care Project, see below:

GTA Rehab Network TOA Guiding Principles	Alignment with the TRC Project
1. Ensure health service providers understand and have knowledge of legislation and policies that guide effective transitions. Which include: • GTA Rehab Network's Repatriation policy. (http://www.gtarehabnetwork.ca/repatriation-policy) • Organizational policies (Example: service guidelines for LHIN Home and Community Care, Hospital's discharge policies) • Accreditation Canada Standards	The TRC project pilot represents an opportunity to revisit some of these policies and legislation as shared by the GTA Rehab Network to help guide effective transitions. Policies specific to bedded level of rehab transitions do not apply to the TRC project, as the transitions focus is only for outpatient, home care and community rehabilitative care.
2. Communicate patient and caregiver preferences and goals to the next level of care	Supported under "Rehabilitative Care Needs" section on the TRC form whereby patient goals are communicated to receiving therapists.
3. Establish one key contact and each transition point	Page 4 of 4 of the TRC form, provides a key contact at the sending organization to ensure receiver can follow up if needed.
4. Standardize organizational processes for transition	As part of the TRC pilot, all participating sites will engage in change management to support the TRC form and streamline organizational processes for transitions.
5. Communicate effectively among health care providers to facilitate transition	TRC form represents a standard consistent template of information to be shared across the various transition points based on the patient's rehab journey.
6. Acknowledge dual responsibility of senders and receivers in transition	The TRC form has been developed using this principle whereby all information needs in the TRC form represent the need for both the receiver and sender, addressing the information gap across the continuum of care for rehab transitions.

APPENDIX A: Home Care Processes Supporting TRC Form Implementation

1. TRC MH LHIN Process from Hospital to Home & Community Care	
2. TRC Process for SPOs initiating a TRC process in the Community	
3. TRC Process for SPOs for referrals received through Hospital	

APPENDIX B: TRC Patient Survey Template

TRC Patient Survey to be provided at last rehab visit or within a week of program discharge	

APPENDIX C: TRC FORMS

Therapist Forms:

Transfer of Rehabilitative Care Digital Form	
Transfer of Rehabilitative Care Manual Paper Form	

Patient Form:

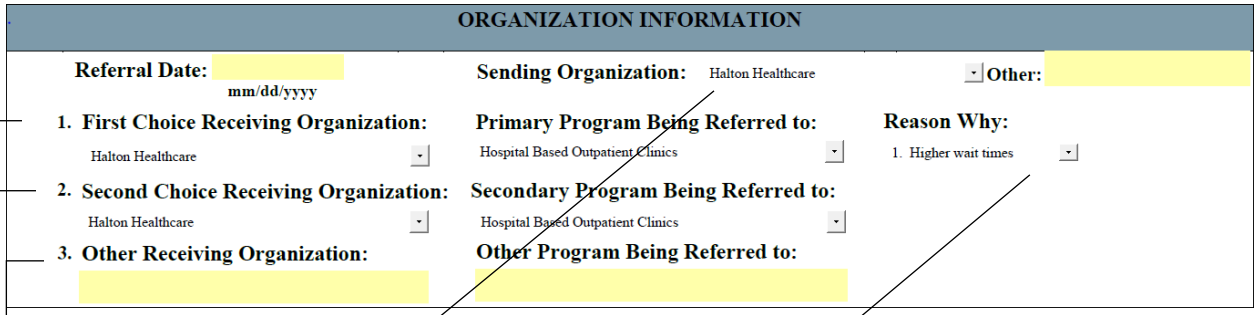
Patient Transfer of Rehabilitative Care Form (Patient Rehab Summary)	

APPENDIX D: Quick Fax Reference Guide for Rehab Programs

Quick Fax reference guide including contact number and fax number of MH LHIN Rehab programs	

APPENDIX E: TRC Form Completion Guide

The following information is designed to help the users of the form understand what information is to be entered in each section when completing the form. It also notes mandatory versus optional fields for the data entry. Please ensure that you review this form completion guide so that you are aware of how to complete each section within the Transfer of Rehabilitative Care form prior to use. Unless otherwise stated (sections that can be skipped or optional) an attempt to complete all data fields must be made.



Referral Date: Enter the date of referral i.e. the day the referral is submitted to another rehab provider. Format: mm/dd/yyyy

Sending Organization: Click on drop down arrow and scroll through list to find the "Sending Organization".
Other: If the organization is not on the list, click on "other" from the drop down list and type the organization name in the text box located to the right of "Sending Organization" drop box.

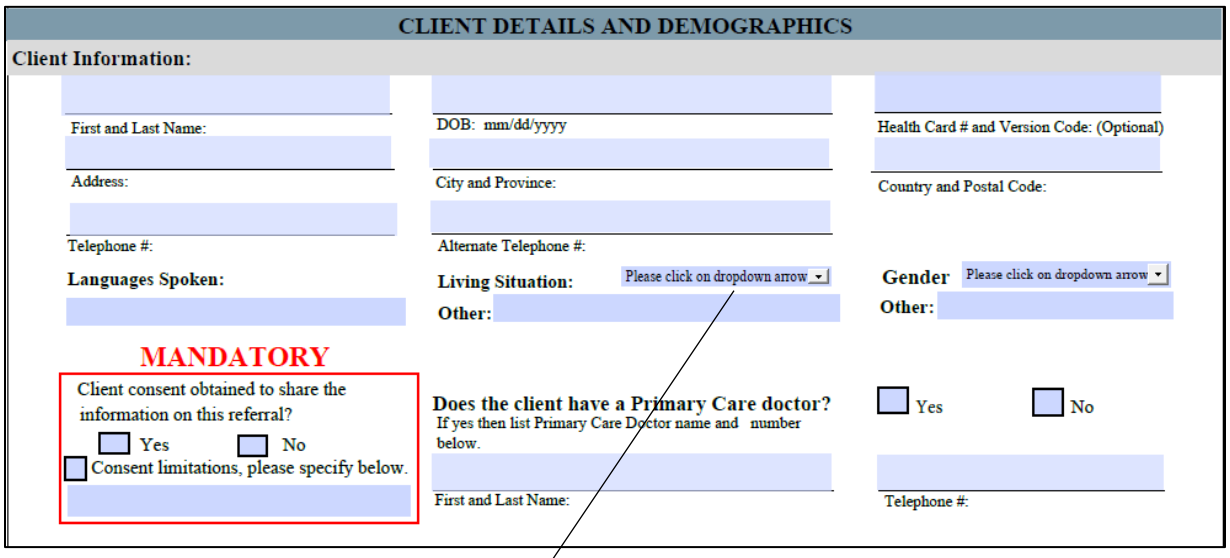
1. **First Choice Receiving Organization:** Click on the drop down box to select your first choice of receiving organization for the patient transfer of rehabilitative care
Primary Program Being Referred to: Some providers have more than one rehab program that they offer, please select from the drop down list which program at your first choice recceing organization are you making the referral to.

Reason Why: This drop down list is used when you are using the same referral for the same patient to go to be sent out to more than one receiving organization. The drop down list includes options for: higher wait times, patient choice, different rehab program, and location.

2. **Second Choice Receiving Organization:** Similar to your first choice for receiving organization, if you are sending the referral to more than one rehab program, please use this data field to select a rehab provider organization and associated program that you are making a referral to under **"secondary program being referred to"**

3. **Other Receiving Organization:** If you need to send a referral to a third rehab provider organization or to a rehab provider that is not listed in the drop down please use this data field to type in their name. Under "**Other Program Being Referred to"** please identify which program at this organization you are referring the patient to.

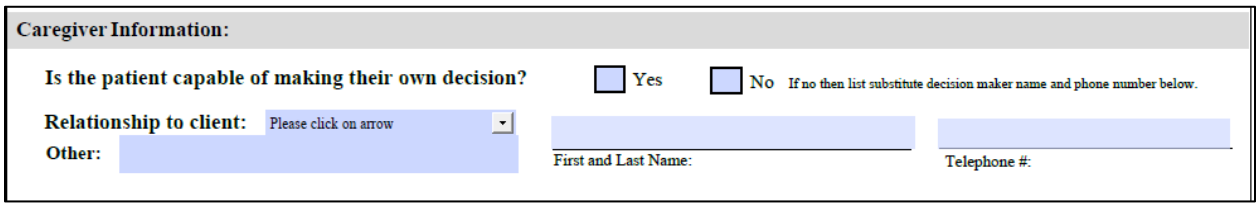
Please ensure that this top section (Organization Information) is completed accurately as it lets all receiving organizations know if the sender has made more than one referral for the same client and to which organizations. This information will help keep everyone in the loop around the various rehab supports required for the patient and the various rehab providers engaged for the delivery the therapy needed.



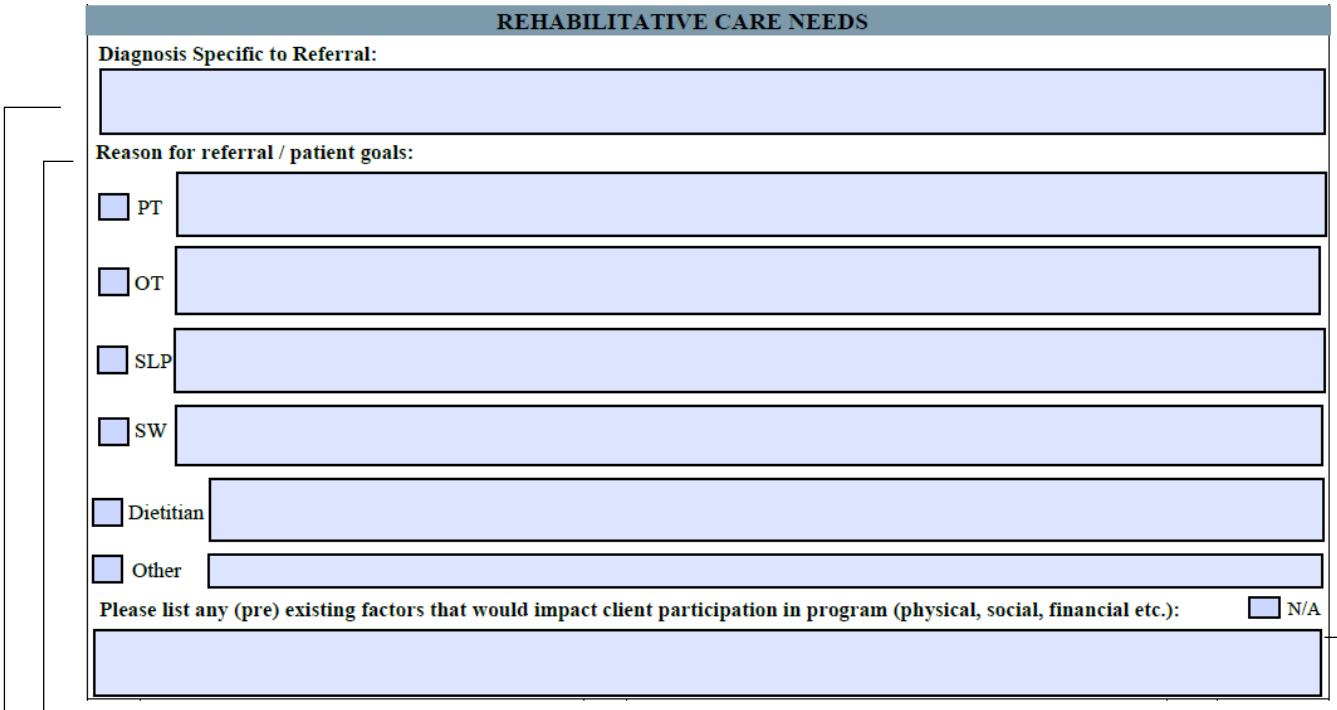
Please complete the client details and demographics section as indicated.

Please note it is very important that if a Transfer of Rehabilitative Care form is being completed that you seek patient consent prior to completing the form. The patient needs to provide permission that their information on the TRC form can be shared with another rehab provider. This consent is to be obtained every time a Transfer of Rehab Care form is completed so at any new transition point. If the patient has provided limited consent, so that information can be shared with select providers only, please ensure that this is accurately reflected in the red box section around client consent on the form. This is mandatory.

Living Situation: As indicated an attempt to complete all sections and data fields on the form should be made, this data field lets the receiving therapists know about the client's current living situation to address occupational therapy and other related supports.



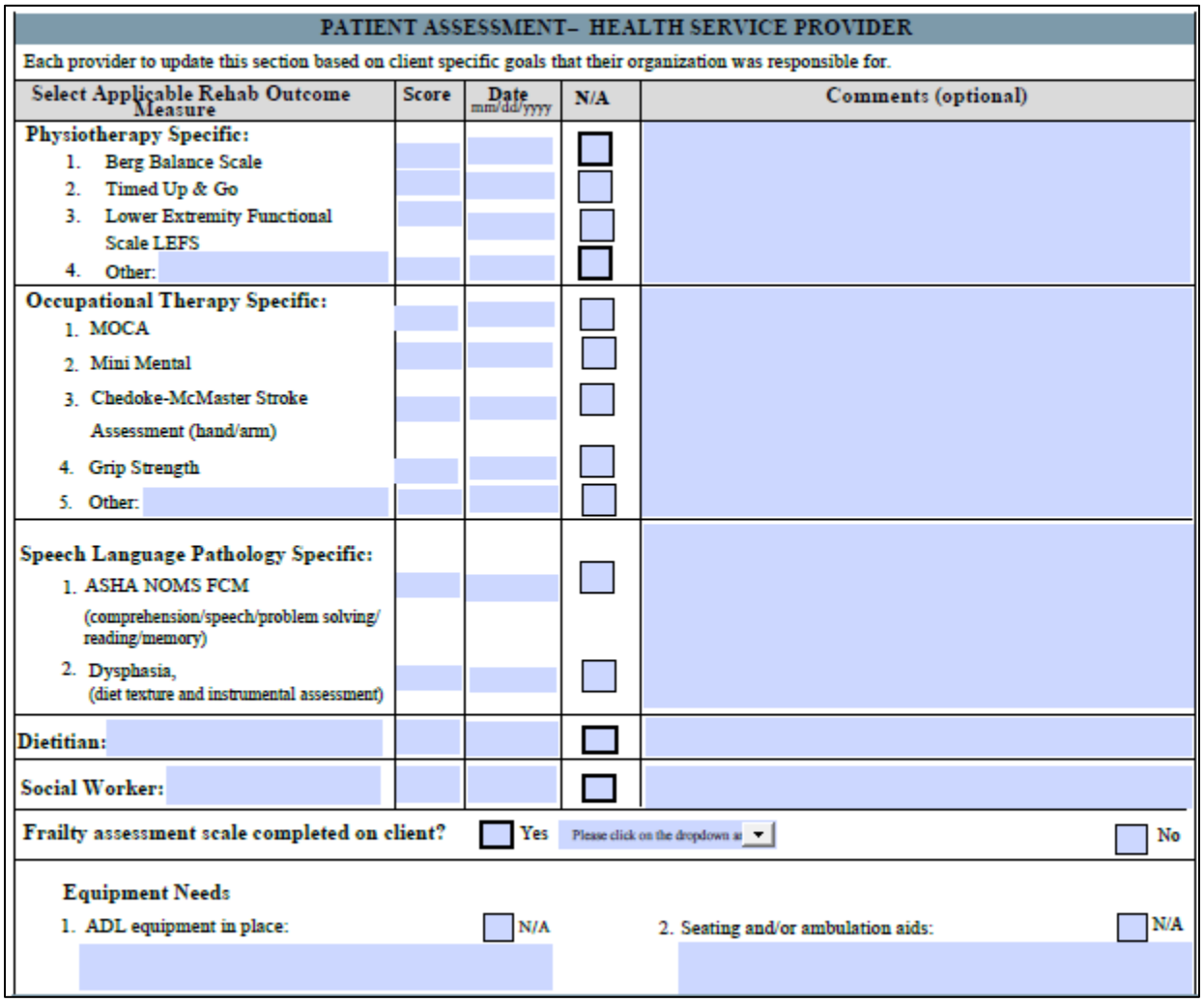
The Caregiver section is an important section to complete for staff completing the TRC form. If the client has a caregiver their contact information should be noted in this section to be shared with the next rehab provider. This helps the receiving organization make in expediting any decisions related to the patient treatment plan or care plan knowing who to contact and saves time.



Diagnosis Specific to Referral: Please identify the medical diagnosis pertaining to the referral being made. I.e. knee replacement surgery requires physiotherapy. Etc.

Reason for Referral/ Patient goals: In this section please clearly communicate what the expected rehab goals or outcomes for the patient are based on your assessment and why the referral is being made to the respective organization. This section has been expanded for allied staff to include allied specific goals for the patient. For example, referral to community step-up program post outpatient neuro stroke rehab at a hospital might indicate. “Additional rehab needed to improve mobility and communication, physiotherapy and speech therapy to manage daily tasks”, including OT, PT and SLP specific notes for patient goals.

Please list any (pre) existing factors that would impact client participation in program (physical, social, financial etc.): please identify any medical conditions/barriers to care could be social, financial for the patient impacting their potential to participate in the program. E.g. “early onset dementia, no caregiver support”.



PATIENT ASSESSMENT– HEALTH SERVICE PROVIDER

Each provider to update this section based on client specific goals that their organization was responsible for.

Select Applicable Rehab Outcome Measure	Score	Date mm/dd/yyyy	N/A	Comments (optional)
Physiotherapy Specific:				
1. Berg Balance Scale				
2. Timed Up & Go				
3. Lower Extremity Functional Scale LEFS				
4. Other:				
Occupational Therapy Specific:				
1. MOCA				
2. Mini Mental				
3. Chedoke-McMaster Stroke Assessment (hand/arm)				
4. Grip Strength				
5. Other:				
Speech Language Pathology Specific:				
1. ASHA NOMS FCM (comprehension/speech/problem solving/ reading/memory)				
2. Dysphasia, (diet texture and instrumental assessment)				
Dietitian:				
Social Worker:				

Frailty assessment scale completed on client? Yes — Please click on the dropdown a — No

Equipment Needs

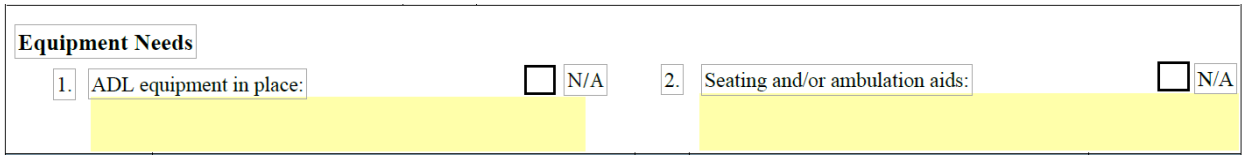
1. ADL equipment in place: N/A
2. Seating and/or ambulation aids: N/A

This is a very important section and acts as a main communication tool for therapists to share discipline specific outcome measures based on their assessment of the patient with the receiving therapist.

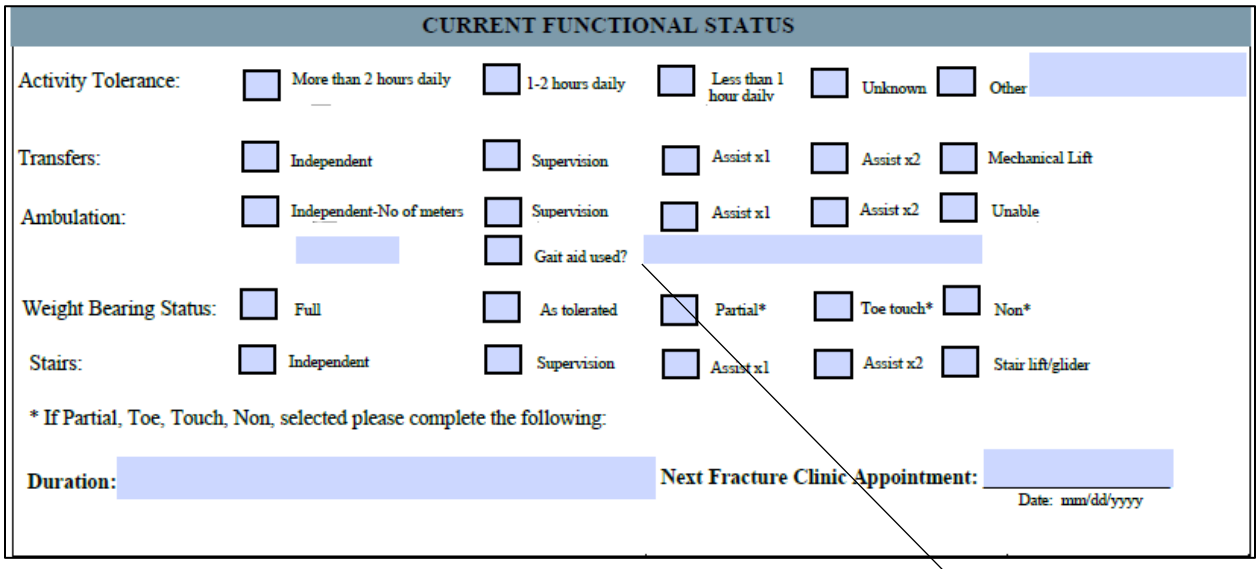
This section is broken down into five professional rehab services, Physiotherapy, Occupational therapy, Speech Language Pathology, Dietician, and Social Work. Based on the service/s received by the client the sending therapists are to complete their specific sections.

Each discipline section has a set of specified or commonly used outcome measures indicated under the discipline. Please select the most appropriate measures used for patient assessment. You will note that there is an “Other” field under the outcome measures section to capture any outcome measures not listed here but used by the therapist. The columns next to the outcome measures ask for a final score of the outcome measure used, the date the particular tool was used to assess the patient, a section that states Not Applicable (N/A, please select if the measures do not apply to the patient being referred) and an optional comments section, allowing the sending therapist to communicate any information with the receiving therapist regarding their patient assessment.

Frailty assessment Scale completed on client: The clinical frailty scale is used as a common tool for the frail and senior population to assess their frailty and supports needed. We have included a copy of this frailty scale towards the end of this guide under Diagram A. Please use the drop down to select the level of frailty specific to the patient being referred. Note this might not apply to all patients being referred based on their age, please check the box that says "No", if the frailty assessment is not completed. Proper training and education should be provided around the use of this tool with clarity around roles and responsibilities for who will be completing the "Frailty Assessment Scale" on the client.



This brief section is to be completed by sending therapists to identify 1) any specific **equipment needs** for the patient, select N/A if this does not apply to your patient. **2) Seating and ambulation aids:** please list any seating or ambulation aids needed for the patient or select N/A if this does not apply.



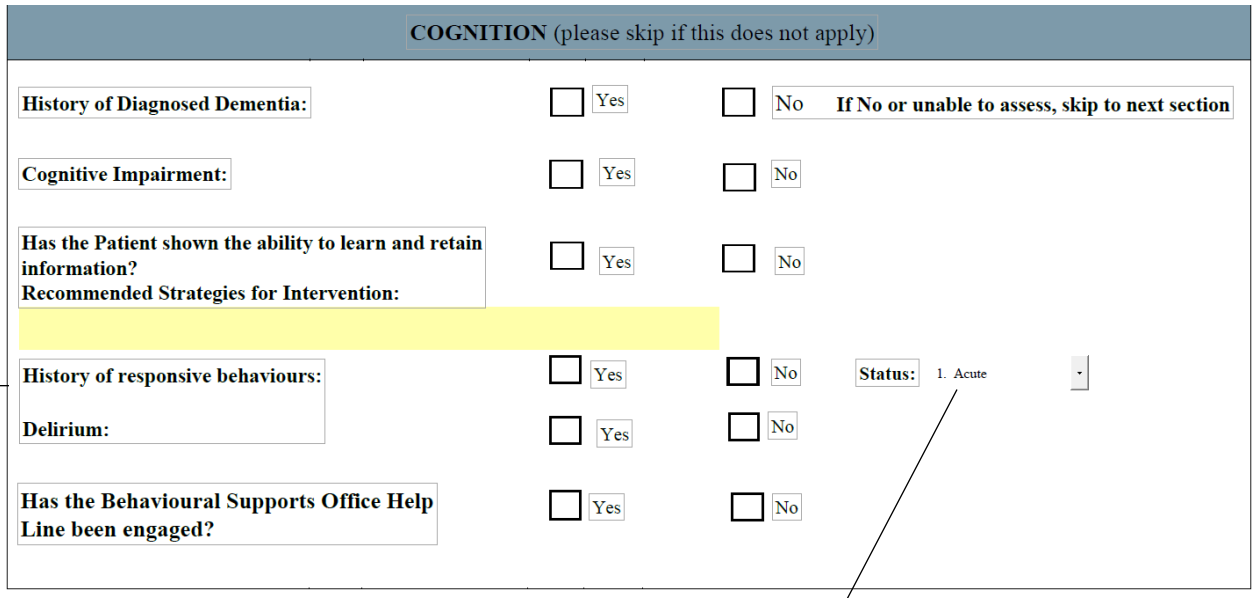
Please complete this section for your patient by simply checking all boxes that apply under sitting tolerance, Transfers, Ambulation, Weight Bearing Status, and Stairs. Please note any gait aid used would be reflected here under ambulation.

ACTIVITIES OF DAILY LIVING (please skip if this does not apply)						
Current Status – Complete the Table Below:						
Activity	**Independent**	**Cueing/Set-up or Supervision**	**Minimum Assist**	**Moderate Assist**	**Maximum Assist**	**Total Care**
Eating: (Ability to feed self)	☐	☐	☐	☐	☐	☐
Grooming: (Ability to self-groom)	☐	☐	☐	☐	☐	☐
Dressing: (Upper body)	☐	☐	☐	☐	☐	☐
Dressing: (Lower body)	☐	☐	☐	☐	☐	☐
Toileting: (Ability to self-toilet)	☐	☐	☐	☐	☐	☐
Bathing: (Ability to wash self)	☐	☐	☐	☐	☐	☐

Use the Activities of Daily Living section to provide additional information about the patient in terms of their functional assessment. Please check all boxes that apply. Please note this is an optional section and might not be required for all rehab transfers.

TRANSPORTATION (please skip if this does not apply) ☐
1. How is the patient going to get to the referred program?
2. If transportation assistance is required, please identify transportation application/s completed.

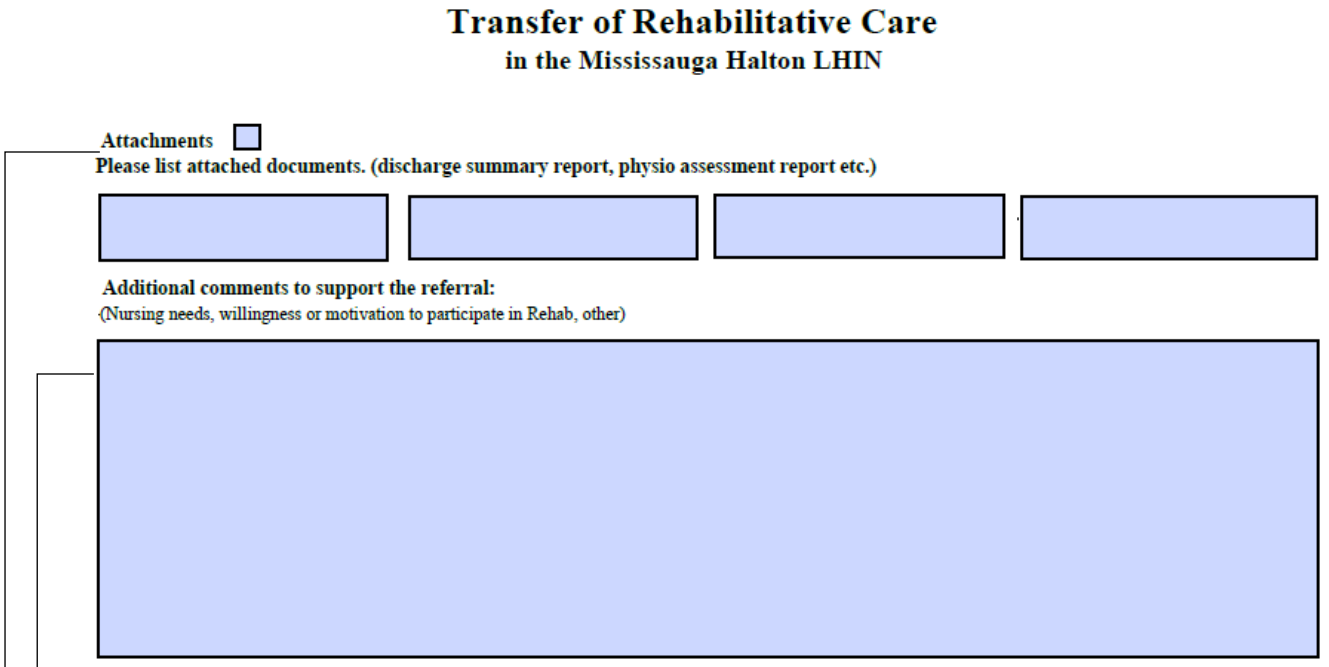
Transportation is an important section to complete for the TRC form as it identifies any barriers to care specific to the patient's mobility or access to mobility affecting their participation in the receiving rehab program. Any information shared here specific to use of public transport or private mode of travelling will help the receiving therapist plan ahead and save time.



Based on the Rehabilitative Care Alliance of Ontario's best practice guidelines questions around cognition should be asked, cognitive impairment should not impact an individual's participation in rehab. However, an early assessment and communication of that assessment allows for appropriate rehab interventions to be planned and used for this patient population. This section allows for a cohesive cognitive assessment of the patient by the sending therapist to help address any dementia or cognitive impairment along with behaviours. This section might not be applicable to all patients so please skip if it does not apply.

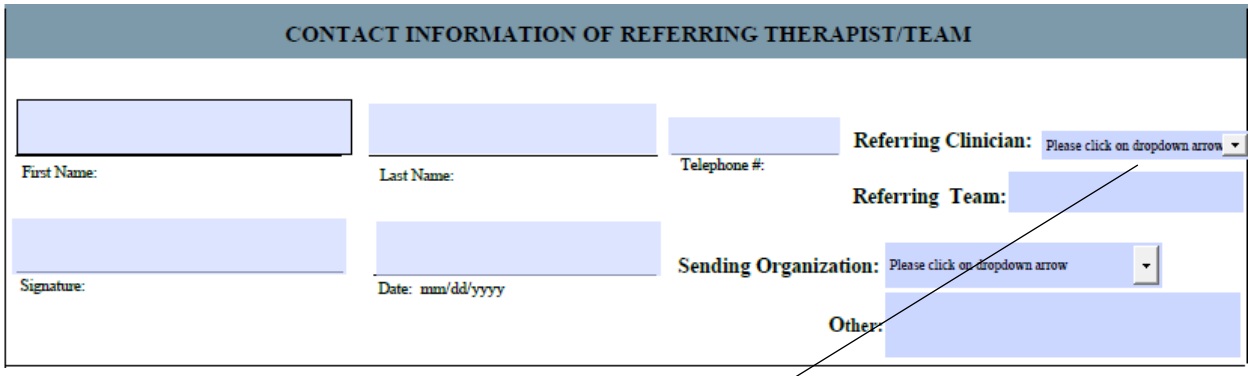
History of responsive behaviours: please select "Yes" or "No" and select a status from the drop down. There are two options under the drop down 1. Acute, 2. Managing well. If assessed please select the appropriate response.

Has the behavioural supports Office helpline been engaged? Please select "Yes" or "No" to identify in case of responsive behaviours if the Behavioural Supports Office for Mississauga and Halton has been engaged.



This section was included to allow for the ability to copy and paste information from hospital discharge reports and therapist summary reports. Any comments from other systems like meditech can be copied and pasted into the "Additional comments to support the referral" section. Along with any other information that the sending therapists would like to share that was not already provided through the TRC form including nursing needs/willingness or motivation to participate in rehab etc.

Please check box if you are attaching any documents with the TRC form so that the receiver know to look for them.



This is the last section of the TRC form. The sending therapist/team must provide their contact details in this section and state their role i.e. occupational therapist, Physiotherapist etc. Select your organization from the drop down menu. The text below is to list an organization that is not presented under the drop down menu list.

Diagram A: CLINICAL FRAILTY SCALE

Very Fit – Individuals who are robust, active, energetic, and motivated. These people commonly exercise regularly. They are among the fittest for their age

Well – Individuals who have no active disease symptom but are less fit than the very fit person. Often these people exercise or are very active occasionally e.g. seasonally

Managing Well – Individuals whose medical problems are well controlled, but are not regularly active beyond routine walking

Vulnerable – Individuals who are not dependent on others for daily help, often have symptoms that limit activities. A common complaint is being "slowed up", and/or being tired during the day

Mildly Frail – Individuals who often have more evident slowing and need help in high order IADLs' (finances, transportation , heavy housework, medications), typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework

APPENDIX F: HSP Pilot Readiness Checklist

Health Service Provider Pilot Readiness Checklist

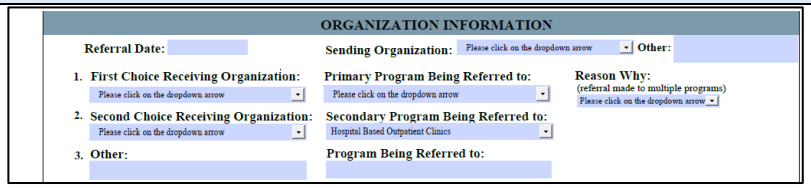
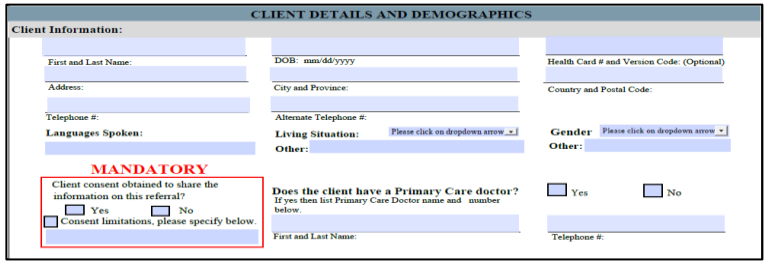
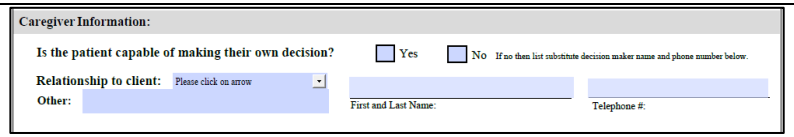
Health Service Provider site champions should review the following checklist to ensure all requirements before the pilot go-live are met and the provider site is marked ready for the pilot.

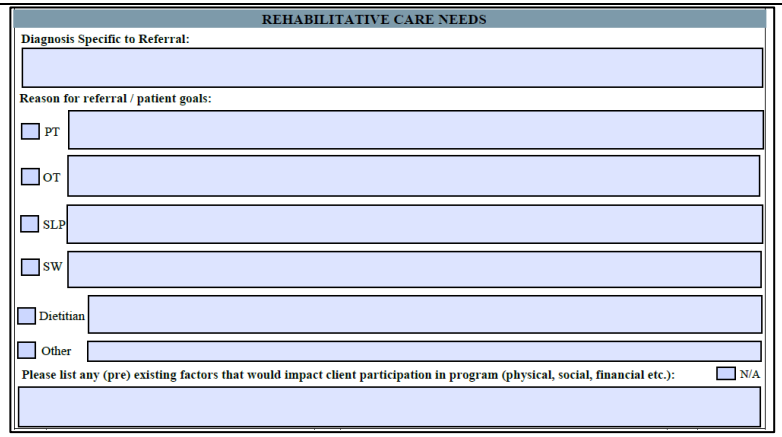
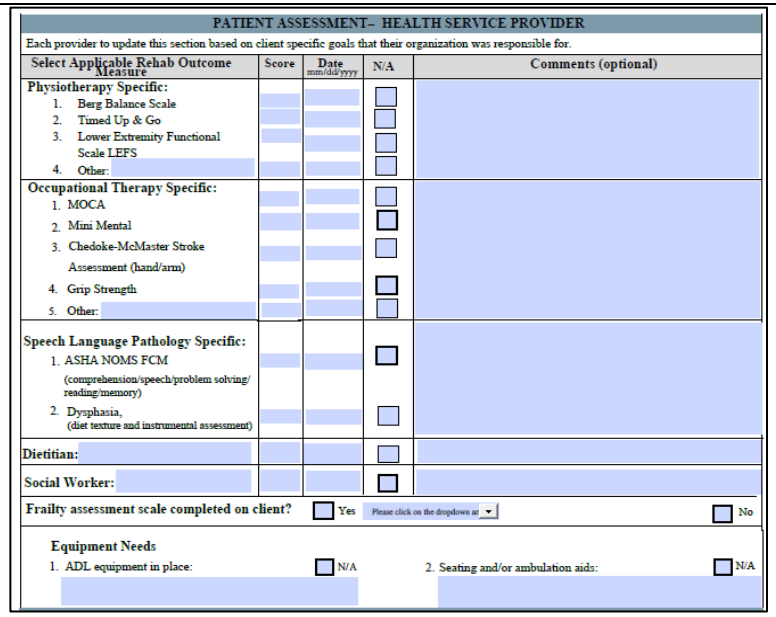
ID #	Deliverable/Action Item	Status (Complete, Pending, In-complete)
1	Project toolkit reviewed and shared with appropriate parties within the organization	
2	All front line staff involved in completing/sending or receiving the Transfer of Rehabilitative Care (TRC) form at the provider site are trained and educated on the Transfer of Rehabilitative Care process, including: • Scope of the pilot • Pilot timelines • Patient and provider evaluation process, & • The TRC process (clear knowledge of what forms to use when i.e. TRC form, patient TRC form, patient survey)	
3	Organization specific local processes to implement the TRC form have been reviewed and updated and discussed with frontline staff	
4	Impacted frontline staff have had the opportunity to go through the TRC form and patient form in a test environment prior to go-live	
5	Project resources available through the RCA Rehab portal have been saved and shared with all impacted staff https://mississaugahalton.rehabcareontario.ca/	
6	TRC form, TRC patient form and patient survey, and quick fax reference guide have been saved in a local accessible space (common drive for accessible forms within organizations) easy to access for all frontline staff. If the form will be used in paper based format, paper based versions are printed and placed in appropriate areas for quick use by staff.	
7	Issues/Opportunities for improvement log has been developed (sample provided in toolkit) to track TRC feedback from frontline staff throughout the pilot period.	
8	Role of a site champion for project related support and questions during the pilot has been shared with frontline staff and managers within each organization.	
9	For the in-scope pilot target populations (Stroke and Hip and Knee Bundle –OTMH only) any outpatient referral forms have been removed/replaced with the TRC form to ensure	

	frontline staff do not revert to using old program based referral forms	
10	Tracking Patients for the Pilot – organization specific processes should be in place. For the duration of the pilot each participating provider site will be asked to track the number of patients referred to other programs using the TRC form. For example within Home and Community Care the TRC will be tracked through CHRIS and through the PSR form submitted to the LHIN by the Service Provider Organizations. A similar process should be put in place at each participating site to track the number of patients referred using the TRC form.	
11	HSP site champions should schedule regular touch points with front line staff to ensure strong uptake of the TRC form and to ensure a smooth pilot cycle.	
12	Process to include TRC patient survey questions within each organization's local survey process has reviewed and necessary steps taken to implement the survey questions prior to go-live (hospital inpatient units excluded). The TRC patient survey is to be provided at the last rehab visit from a program or post 1 week of program discharge.	
13	Ensure TRC patient survey has a return address and contact information for your organization for patients to submit completed surveys.	
14	Ensure a filing process for all manually submitted TRC patient surveys is in place. These patient surveys will be collected at the end of the Pilot by the project team for analysis.	

APPENDIX G: TRC Form Issues/Opportunities for Improvement Tracking Log

To be used by Health Service Provider site champions to track feedback on TRC form throughout the pilot.

	Section within TRC Form	Issues/Opportunities for Improvement		
		Whole section (specify if the whole section needs to be reviewed)	**Data Fields** (Specify exact data fields)	**Suggested improvements** (Remove, edit, or add additional information to the related data fields/sections in the form, please specify)
1				
2				
3				

4	 REHABILITATIVE CARE NEEDS Diagnosis Specific to Referral: Reason for referral / patient goals: PT OT SLP SW Dietitian Other Please list any (pre) existing factors that would impact client participation in program (physical, social, financial etc.): N/A			
5	 PATIENT ASSESSMENT– HEALTH SERVICE PROVIDER Each provider to update this section based on client specific goals that their organization was responsible for. Select Applicable Rehab Outcome Measure Score Date mm/dd/yyyy N/A Comments (optional) Physiotherapy Specific: 1. Berg Balance Scale 2. Timed Up & Go 3. Lower Extremity Functional Scale LEFS 4. Other: Occupational Therapy Specific: 1. MOCA 2. Mini Mental 3. Chedoke-McMaster Stroke Assessment (hand/arm) 4. Grip Strength 5. Other: Speech Language Pathology Specific: 1. ASHA NOMS FCM (comprehension/speech/problem solving/ reading/memory) 2. Dysphasia, (diet texture and instrumental assessment) Dietitian: Social Worker: Frailty assessment scale completed on client? Yes No Equipment Needs 1. ADL equipment in place: N/A 2. Seating and/or ambulation aids: N/A			

6

CURRENT FUNCTIONAL STATUS

Activity Tolerance: ☐ More than 2 hours daily ☐ 1-2 hours daily ☐ Less than 1 hour daily ☐ Unknown ☐ Other

Transfers: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Mechanical Lift

Ambulation: ☐ Independent-No of meters ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Unable
☐ Gait aid used?

Weight Bearing Status: ☐ Full ☐ As tolerated ☐ Partial* ☐ Toe touch* ☐ Non*

Stairs: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Stair lift/glider

* If Partial, Toe, Touch, Non, selected please complete the following:

Duration: **Next Fracture Clinic Appointment:** Date: mm/dd/yyyy

7

ACTIVITIES OF DAILY LIVING (please skip if this does not apply) ☐

Current Status – Complete the Table Below:

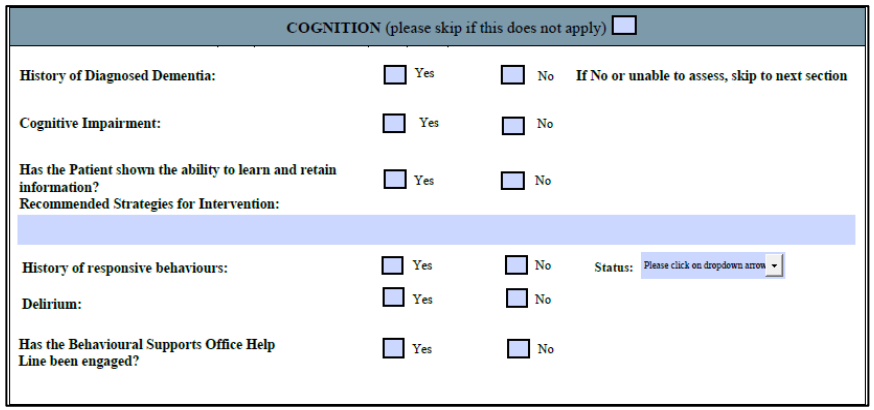
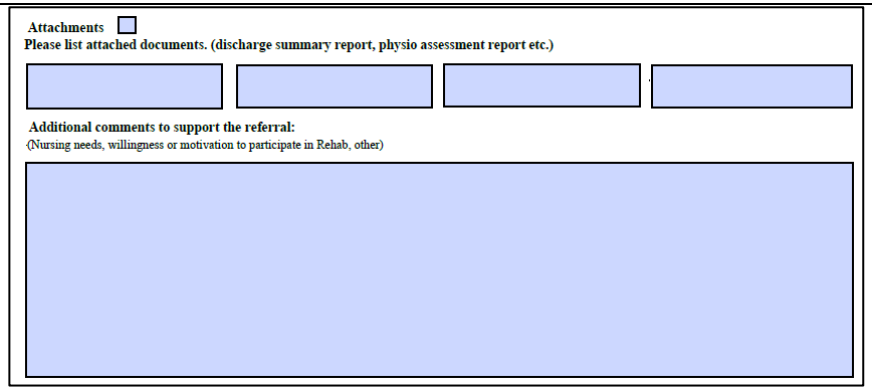
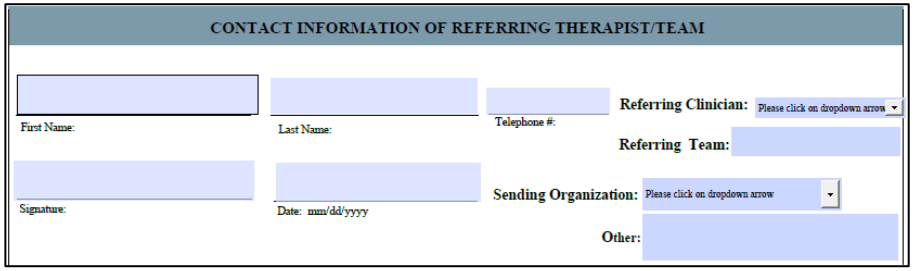
Activity	Independent	Cueing/Set-up or Supervision	Minimum Assist	Moderate Assist	Maximum Assist	Total Care
Eating: (Ability to feed self)	☐	☐	☐	☐	☐	☐
Grooming: (Ability to self-groom)	☐	☐	☐	☐	☐	☐
Dressing: (Upper body)	☐	☐	☐	☐	☐	☐
Dressing: (Lower body)	☐	☐	☐	☐	☐	☐
Toileting: (Ability to self-toilet)	☐	☐	☐	☐	☐	☐
Bathing: (Ability to wash self)	☐	☐	☐	☐	☐	☐

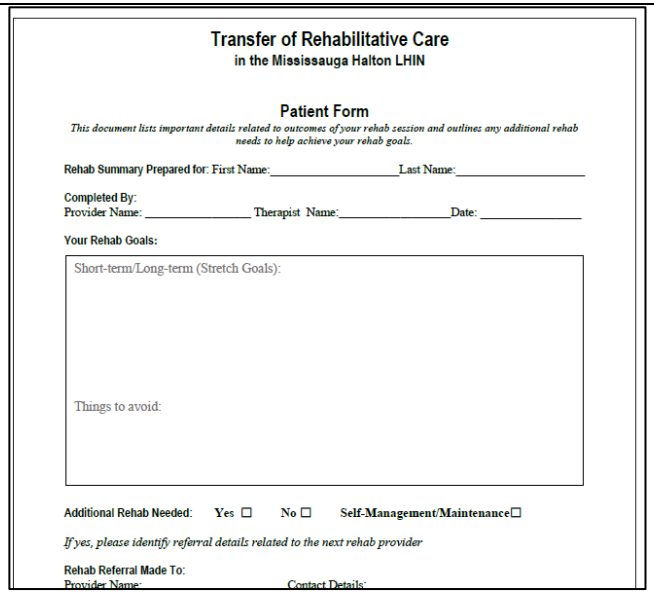
8

TRANSPORTATION (please skip if this does not apply) ☐

1. **How is the patient going to get to the referred program?**

2. **If transportation assistance is required, please identify transportation application/s completed.**

9	 COGNITION (please skip if this does not apply) History of Diagnosed Dementia: Yes No If No or unable to assess, skip to next section Cognitive Impairment: Yes No Has the Patient shown the ability to learn and retain information? Yes No Recommended Strategies for Intervention: History of responsive behaviours: Yes No Status: Please click on dropdown arrow Delirium: Yes No Has the Behavioural Supports Office Help Line been engaged? Yes No			
10	 Attachments Please list attached documents. (discharge summary report, physio assessment report etc.) Additional comments to support the referral: (Nursing needs, willingness or motivation to participate in Rehab, other)			
11	 CONTACT INFORMATION OF REFERRING THERAPIST/TEAM First Name: Last Name: Telephone #: Referring Clinician: Please click on dropdown arrow Referring Team: Signature: Date: mm/dd/yyyy Sending Organization: Please click on dropdown arrow Other:			

12				

Transfer of Rehabilitative Care
in the Mississauga Halton LHIN

Patient Form

This document lists important details related to outcomes of your rehab session and outlines any additional rehab needs to help achieve your rehab goals.

Rehab Summary Prepared for: First Name:_____Last Name:_____

Completed By:
Provider Name: _____ Therapist Name:_____Date: _____

Your Rehab Goals:

Short-term/Long-term (Stretch Goals):

Things to avoid:

Additional Rehab Needed: **Yes** ☐ **No** ☐ **Self-Management/Maintenance**☐

If yes, please identify referral details related to the next rehab provider

Rehab Referral Made To:
Provider Name: Contact Details:

APPENDIX H: Online Resource for TRC Project Documents

An online project resources link has been set up to provide all project documentation, TRC forms, Patient surveys and other supporting documents for the pilot including this toolkit through the RCA Rehab Portal. Please see links below to access the TRC pilot resources page.

https://mississaugahalton.rehabcareontario.ca/

https://mississaugahalton.rehabcareontario.ca/156/Transfer_of_Rehabilitative_Care_Pilot_Project/

APPENDIX I: TRC Form FAQ

TRC FORM: FREQUENTLY ASKED QUESTIONS

1. What's the benefit of using a Transfer of Rehabilitative Care Form?

The Transfer of Rehabilitative Care (TRC) form addresses a common gap within our system of the lack of information around patient care shared across rehab providers involved in providing services to the patient throughout the patient journey.

The Problem:

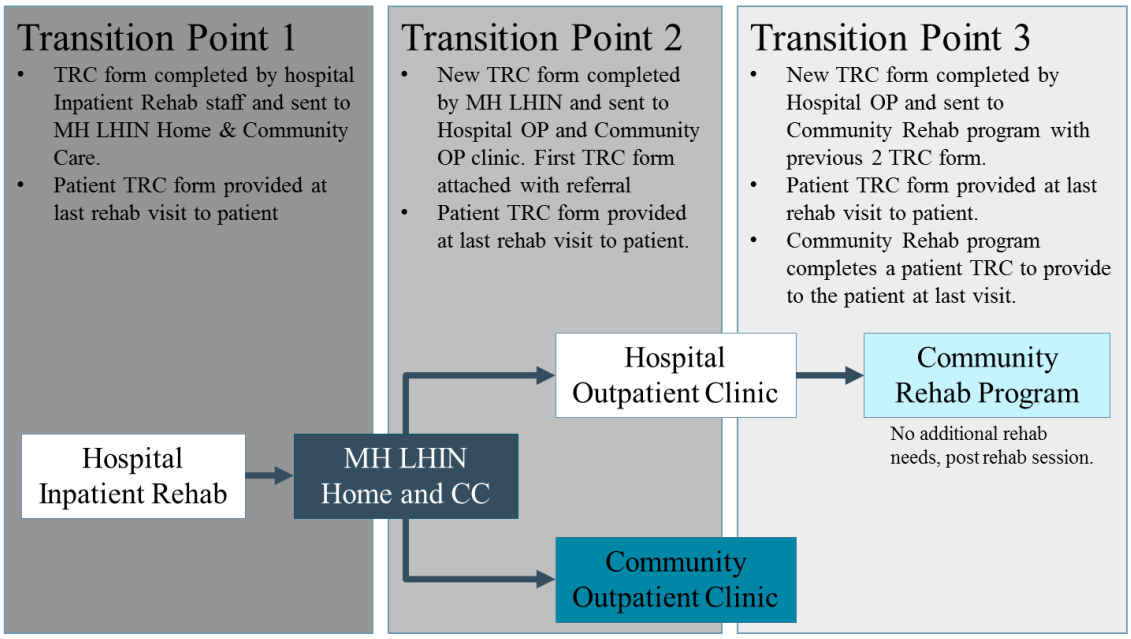
- This current information gap puts a strain on the receiver of a rehab referral to contact the sender to get more information on the patient to prepare for the client appointment.
- In turn, the receiving program therapists might have to ask the patient questions about their rehab/medical history, leaving the patient frustrated and with a poor experience.
- Sometimes the type of information that is shared is not relevant or consistent across the various rehab providers.
- There is a lot of time and effort spent on trying to find the right information by calling the sending organization back multiple times.
- When making an outpatient rehab referral therapists have to look through receiving rehab program specific referral forms and requirements that vary by organization, again leading to more time being spent looking for information and completing different forms with different information needs per organization.

The Solution:

- The TRC form addresses this information gap by ensuring there is one common rehab referral form that is used for all outpatient rehab programs supported by an allied staff. These outpatient rehab programs can be offered in the community or hospital. The TRC form will eliminate the need to look for organization specific rehab referral forms through the use of one commonly accepted rehab form (TRC) for all publicly funded rehab programs. This included all hospital outpatient/ambulatory rehab clinics and community rehab programs supported by allied staff.

- The TRC form is to be used for recording patient information specific to admission and discharge, separate discharge documents are not required when using a TRC form.

- The TRC form will allow rehab providers to consistently get the same rehab information for their patients and allows for each TRC form at each transition point to be shared with the receiving program. Please see example below:



In its current state the TRC will be implemented in a manual paper based environment with future technology e-referral/record management platforms to be explored.

2. When should a Transfer of Rehabilitative Care Form (TRC) be used?

A TRC for is to be used when making a rehab referral to any outpatient program in the hospital, home care, and/or community supported by allied health staff. It is a therapist to therapist referral such as Physiotherapists (PT), Occupational Therapists (OT), Speech Language Pathologists (SLP), Dietician, Social Worker (SW) etc.

If rehab goals have been met and no additional rehab referral to other programs is needed then a TRC should not be completed.

The TRC form should not be completed for OT pre-discharge assessment, usually requiring 1-2 home visits or for referrals to private therapists, community support program not offered through allied supported staff, and or rehab programs not funded by the Ministry of Health or Mississauga Halton LHIN.

3. When should the Patient Transfer of Rehabilitative Care Form be used?

The Transfer of Rehabilitative Care initiative has been developed keeping the patient experience in mind as well allowing for a common vehicle (form) to be used between rehab providers to share important patient information to address the information gap. Having patients at the center of our planning, it is very important that the patient version (1 page form) be used at the last patient visit or at time of discharge from a rehab program. The purpose of the patient TRC for is to:

- Provide a paper copy or record to the patient about their rehab goals
- If another transfer of rehab care is required provide information on the referral made
- Have the patient use this form for their own record management and note taking (page 2 of the patient TRC form)

4. How is the Transfer of Rehabilitative Care Form completed? On paper or electronically?

The TRC form is completed based on each organization's current referral systems and processes. The form will be provided in a paper format and electronically where drop down lists can be used with ease to save time. We understand that currently all health service provider organizations have different referral systems and most organizations use fax as the preferred method for transmitting a referral. If you have the ability to use the form electronically we recommend you do that since it will make it easier and saves time to complete with the Drop Down options, allowing the opportunity to copy and paste information from other patient information systems like meditech. However, we understand that not all staff have a lap top with them all the time and therefore will need to complete the form in a manual paper format, therefore we have provided two versions of the form 1) manual paper based 2) electronic with drop down and copy and paste options. A form reference guide and quick reference guide including all outpatient rehab programs with fax numbers is also provided in the toolkit to help therapists in processing the referral once completed.

5. How many people and who should complete the Transfer of Rehabilitative Care (TRC) form?

Depends on the rehab program and the rehab service delivery model. There are different models out there in hospitals and community, programs are either delivered via single discipline or through a multidisciplinary team model. If it is a single discipline then the most responsible discipline providing patient care will be responsible to complete the form and send it to the receiver. If it's a multidisciplinary team approach then each discipline can complete their specific sections of the form, communicate within the team that they have completed their sections on the TRC form and the last person responsible for providing treatment or care to the patient will complete the remaining sections and send the form to the next rehab provider.

6. There is no place for a physician to sign off on the Transfer of Rehabilitative Care (TRC) form? How do I capture a physician signature if required?

The Transfer of Rehabilitative care form is to be used for all outpatient, home care and/or community rehab programs publicly funded and supported by allied staff. A physician signature in most cases should not be required. However, we understand for some cases a physician signature might be required based on specific rehab populations, or where an outpatient program requires it based on an organization's discharge practice or policy to address a particular patient's care needs. In such circumstances the physician order form would be part of a physician order set and can be attached on the last page of the TRC form page 4 of 4, under "Attachments".

7. How long will the TRC pilot be? And how will it be evaluated?

The Transfer of Rehabilitative Care pilot is planned to begin in Nov, 2019. The pilot will last 3-4 months, where it will be evaluated and any necessary changes will be made to the TRC form. Any pilot sites using the TRC form will continue to use the form with suggested changes post pilot evaluation; while the project team prepares a regional implementation plan to ensure all remaining rehab provider organizations can implement the TRC form moving forward.

The pilot will be evaluated at a 3 month (mid pilot) and at pilot end check point through a survey monkey that will be developed by the project team and administered by the project team through your Health Service Provider site champions. The objective of the 3 month check in survey is to ensure that if there are any immediate issues/challenges with the TRC form impacting patient care, they are mitigated before continuing with the remaining duration of the pilot. A patient survey on the TRC will also be administered by the HSPs, and will be provided to the patients at their last rehab visit or within 1 week of program discharge. The patient survey is developed by the project team and all responses on the patient survey will be analyzed and assessed by the project team at the end of the pilot.

8. What if I have questions on the TRC project who should I talk to?

The project is being led by the Regional Programs Portfolio at The Mississauga Halton LHIN. The project lead is Amy Khan who can be reached at amy.khan@lhins.on.ca. However, to ensure that staff at all participating organizations are fully supported throughout the pre-pilot "training and education" phase and through the 3-4 month pilot life cycle, we have identified Health Service Provider (HSP) site champions at each participating rehab organization. These HSP site champions will be your main point of contact throughout the pilot and will be available to address any questions you might have on the TRC pilot. The HSP site leads work closely with the LHIN project team to ensure that all questions are addressed in a coordinated and timely manner and any issues/risks flagged with an appropriate mitigation strategy in place. Please see below for details around the roles and responsibilities for an HSP site champion.