Transfer of Rehabilitative Care (TRC) Project Overview

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

October 2019

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

The Problem

- Information sharing gap: No current standard for sharing standardized rehab information between rehab providers for outpatient rehab.
- Access to programs: (Impact to patient care and wait times)
  - Providers have to spend more time calling the sender to get more rehab information to plan for their patient.
  - Providers have to look for organization specific referral forms with varying levels of data requirements when referring patients.
- Patients have to “repeat their story multiple times” at various provider settings due to the lack of history on file. Leaving patients frustrated and with a negative experience.

Transfer of Rehabilitative Care (TRC)

- Mississauga Halton 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.
- A TRC form is completed and shared with other rehab providers if client rehab goals in the current setting are not met or if client is identified as a rehab candidate.
- TRC 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.
- **TRC form will replace all existing rehab outpatient referrals forms with one common form.**

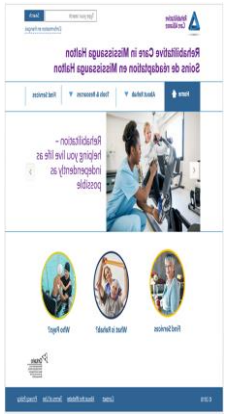
Alignment with Provincial/ Regional Priorities

- ✓ Addressing the information gap
- ✓ Seamless transitions to care
- ✓ GTA Rehab Network Inter-organizational Transfer of Accountability guiding principles.
- ✓ Devlin's Interim Report from the premier's council on improving Healthcare and ending hallway medicine.
  - Patient experience (access and navigation to healthcare)
  - Responsibility and Accountability in Health Care
    - "There is such a gap in the transitions of care…the interest is not on the patient, but on each individual health service provider's own unique budget and strategic objectives" *(patient survey response)*
    - "The staff have all been kind and professional…the negative issue would be the constant need to provide basic information like address, date of birth, medications, family doctor, allergies, and more. It is very frustrating for a senior to be asked the same questions." *(patient survey response)*

Two stages of processing a rehab referral

Step 1

MH LHIN Rehab Portal



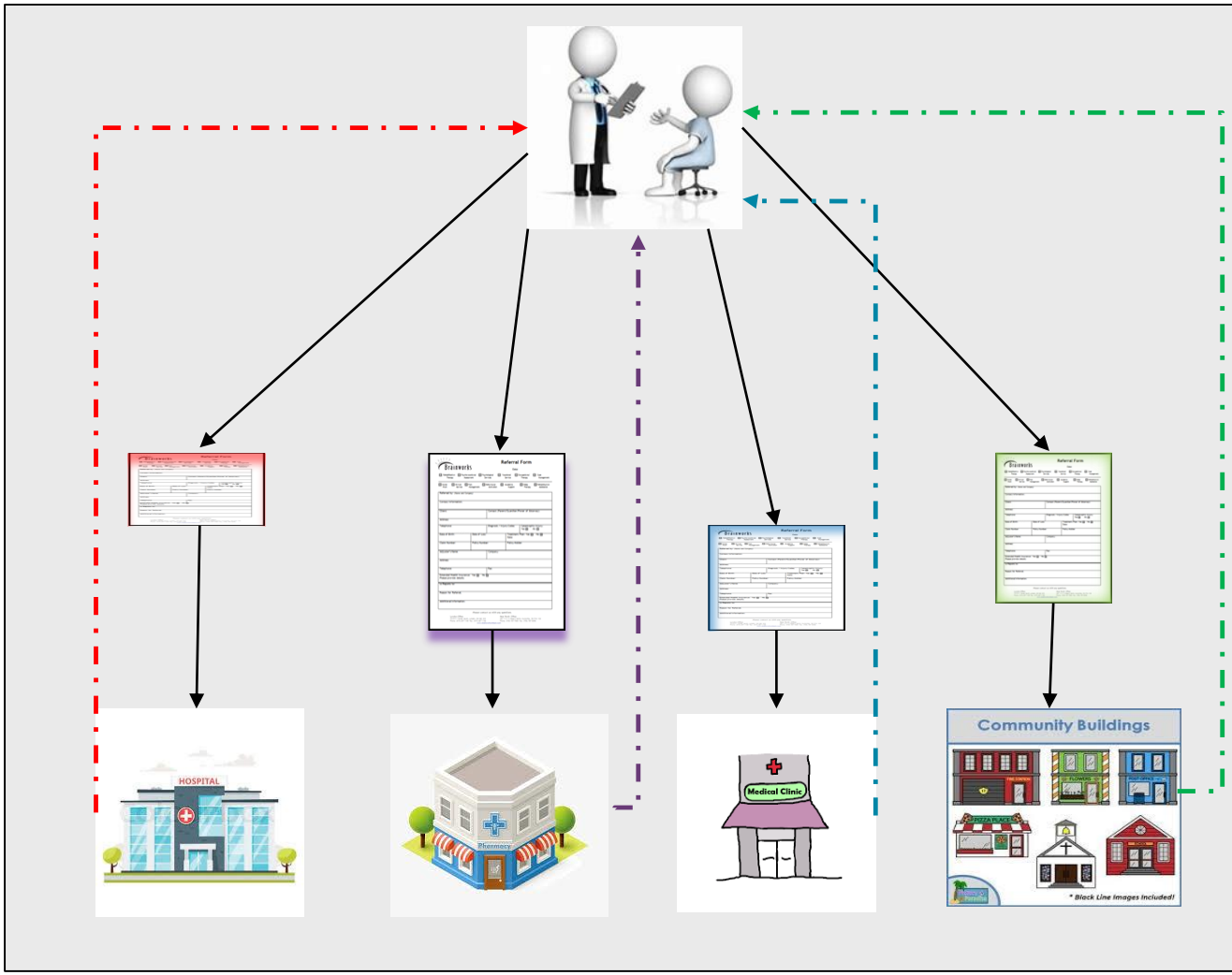
Where do I send this Referral?

Step 2

How do I send this Referral? Which form do I use? What information do I share?

Transfer of Rehabilitative Care

Rehab Referrals – Current State



Different organization based referral forms used for different rehab providers

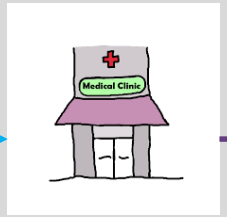
Type of information shared varies from provider to provider

Information received by the rehab provider is not sufficient to make decision around rehab treatment goals. Resulting in the receiver having to go back to the sender and re-assessing patient for something they would have already been assessed for.

Rehab Referrals – Future State

Physiotherapy

Speech Language



One common rehab form: Transfer of Rehabilitative Care used for all providers

Standard Minimum Data Set on form, ensures all providers get the same information for rehab referrals.

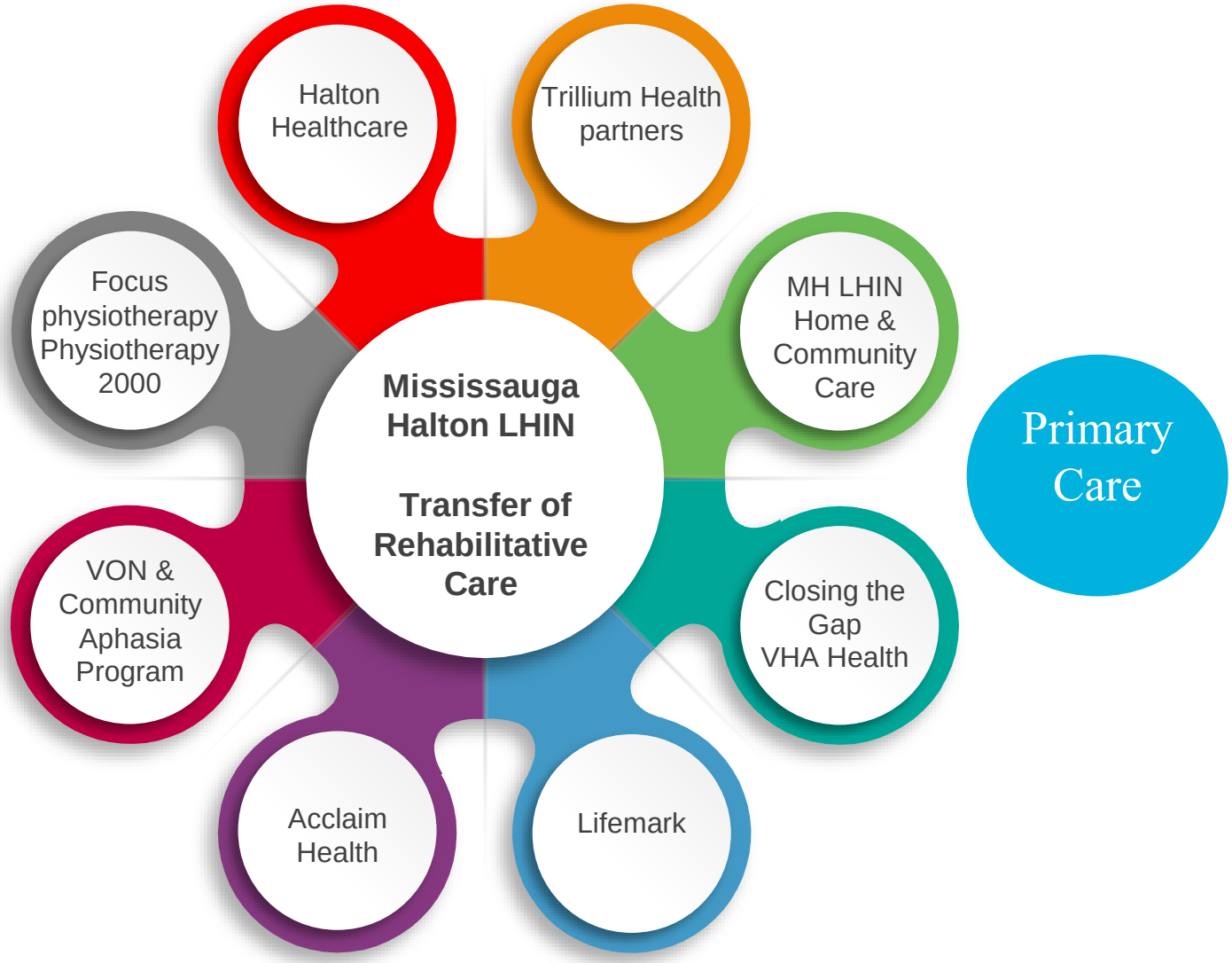
Helps providers not repeat questions with patients and use information shared to start rehab goals

Scope

- Scope: Inpatient (acute or rehab) to in-home rehabilitative services home; to outpatient sector, community rehab (CPCs), and other community rehab programs.

- Referrals don’t have to originate from the Hospital, any one who is responsible for providing rehab first to the client will initiate the Transfer of Rehabilitative care form.

Stakeholder Engagement



Benefits – The Opportunity

Patients

- Don't have to repeat their story twice
- Can come to their first appointment and feel confident about starting their rehab therapy immediately
- Focused follow up
- Improved patient experience
- Patients get a copy of their TRC along the transitions of care

Provider

- Using one referral form for making referral to all community and OP rehab programs
- Access to past treatment goals and functional status data that was not previously shared –bridging the information gap
- Ability to develop a rehab care plan prior to the patient arriving

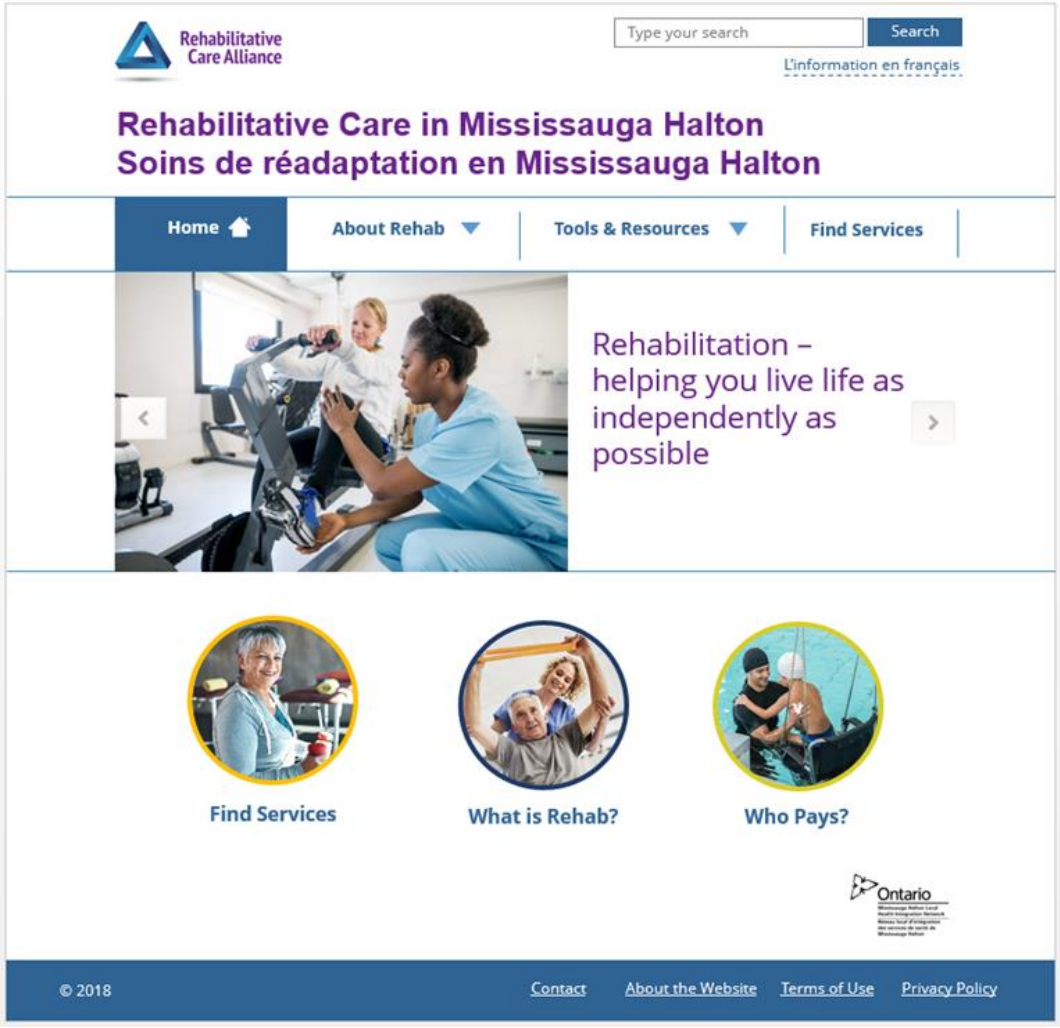
System

- Elimination of multiple referral forms
- Saved time and resources on completing different referral forms.
- Better care planning through seamless transitions
- Transparency in transferring the accountability from one provider to the next specific to achieving patient rehab goals

Integration & Partnerships through seamless transitions
Continuity of Care

Which Rehab Program Should I Refer to?

Mississauga Halton LHIN Rehab Portal: Designed for Health service providers, Patients and families.



Mississaugahalton.rehabcareontario.ca

Find information on:

- Rehab program eligibility
- Locations
- Hours of operation

Filter Services by:

- Community based rehabilitative care
- Hospital based outpatient-rehabilitative care
- Inpatient rehabilitative care
- Rehab population specific programs

Live March 2019

thehealthline.ca
INFORMATION NETWORK

Project Resources available online through RCA Rehab Portal

Project toolkit, TRC forms, patient survey template and other supporting documents available online under Tools and Resources>Transfer of Rehabilitative Care Pilot Project

https://mississaugahalton.rehabcareontario.ca/

5 Stages of Using a TRC form

Patient gets a copy of their TRC through out the process

1

INQUIRY/ DSICHARGE READY

Client has met their rehab goals for your organization and is ready for the next level of rehab care setting.

You are now ready to refer client to the next community or hospital based program to achieve their rehab goals

2

COMPARISON

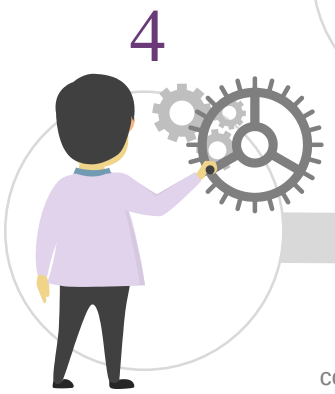
Search MH LHIN Rehab Portal for programs/ services available. Compare programs offered through multiple available filters to clients. (Location, therapy model, appropriateness)

3

REFERRAL

Providers can make a referral to the chosen rehab program/s by completing the TRC form and sending it to one or more providers.

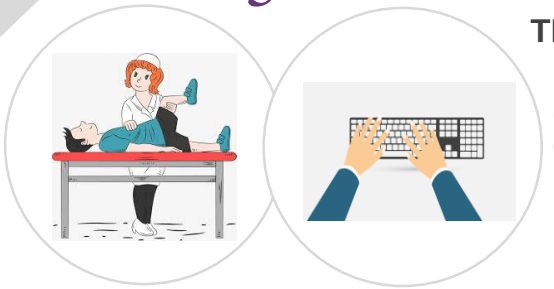
4



SERVICES RECEIVED

The health service provider who will receive the TRC, will then initiate the service request by reaching out to the client and booking an appointment .

5



THERAPY COMPLETED & READY FOR DISCHARGE

Once the service has been initiated and therapy provided to client. The client can either be discharged home with no further rehab needs at the time, or

Referred to another rehab program if needed using the same TRC form. The first provider will update the TRC with results from their treatment goals and identify client progress before sending the TRC to the next provider in line

Rehabilitation Continuum of Care – example

“ Imagine knowing the whole history of any client’s rehab journey through one shared TRC form, when they arrive at your door”

Hospital Acute/IP Rehab Discharge

Initiate TOA

Directly to Community Rehab

Inpatient Rehabilitation

Home care Rehabilitation

Outpatient Rehabilitation

MSK Clinic at Hospital

Community Physio Clinic

OR

Referred to Home based exercise program –VON SMART Enhanced (2 X week for 6 weeks)

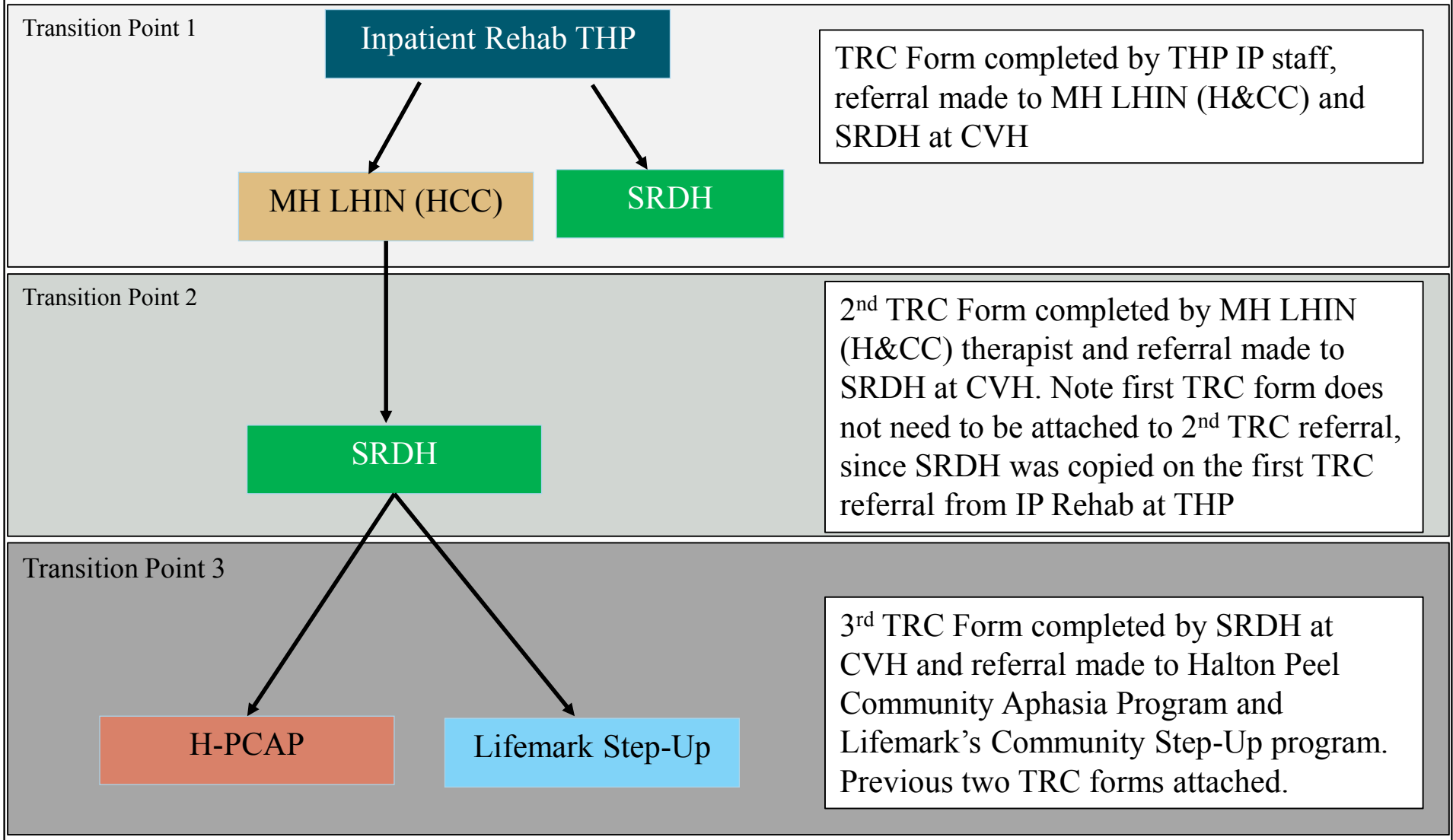
Further functional decline

Homecare referred her to a multidisciplinary team (OT,PT, SLP) Community Step – Up Clinic 3 locations

Identified as a Falls Risk ,so the Community Step Up team referred her to one of the 71 locations for Falls and exercise offered across the MH LHIN, close to her home

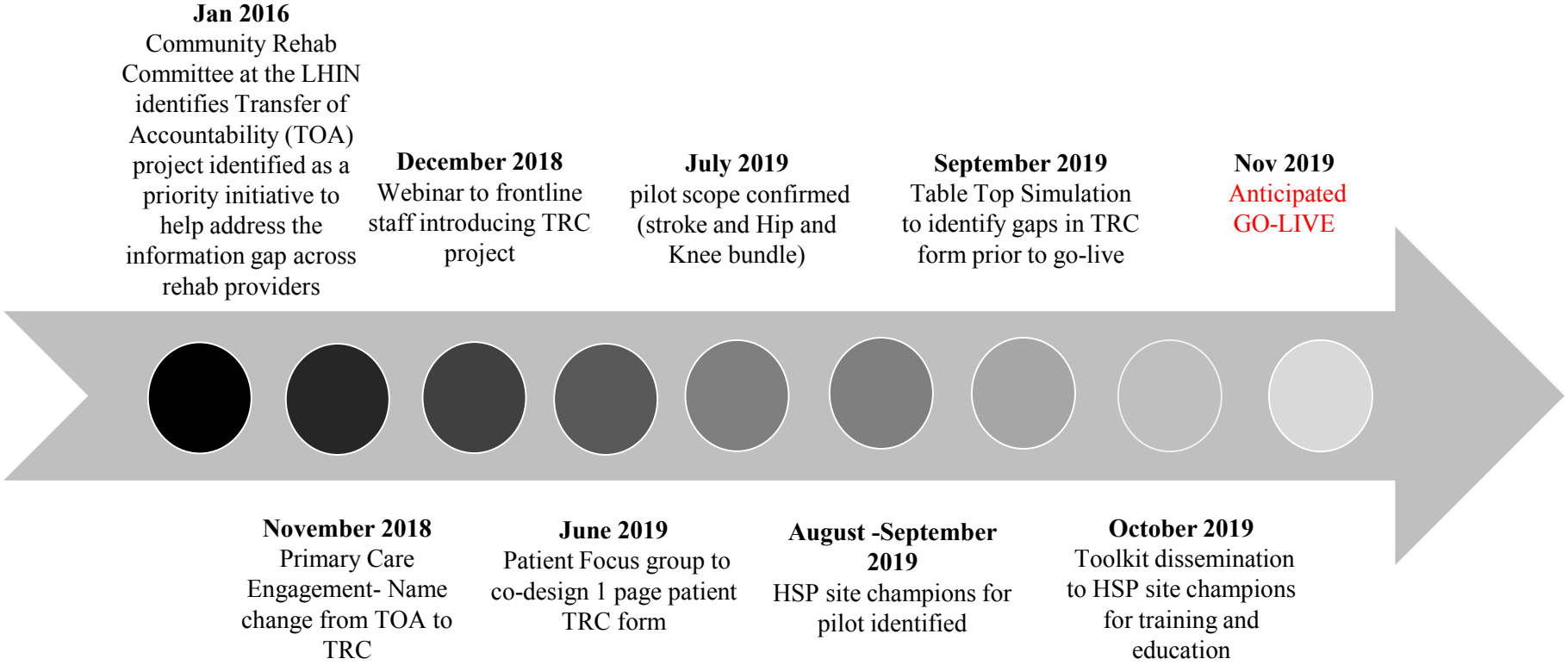
Two way referrals, anyone can initiate a Transfer of Rehabilitative Care

TRC Sample Referral Flow -Stroke



TRC referrals are to be used for allied health supported outpatient rehab programs. Referrals to community support programs and private therapists and to bedded rehab do not require a TRC form.

Major Milestones



TRANSFER OF REHABILITATIVE CARE –Pilot

Outpatient Population: Stroke and Hip and Knee Bundled Care

Pilot HSPs: HH – Oakville (to be confirmed), THP –Credit Valley Hospital, Halton Peel Community Aphasia Program, Lifemark Community Step-Up, VHA, Closing the Gap, CBI Health, St. Elizabeth Homecare, MH LHIN Home and Community Care

Units/Departments: THP-CVH (1D), Seniors and Rehab Day Hospital –CVH

Staff education/training: Frontline line staff at participating sites engaged, job aids and implementation toolkit in development

Time frame: 3-4 months (Proposed: Fall 2019 – March 2020)

Evaluation: baseline survey established through provider survey (April 2019), evaluation audience(HSPs/SPOs and patients and families). Evaluation criteria includes TRC content for providers and patient questions specific to repeating their history.

TRC – Patient One Pager

To be shared at point of discharge at each rehab provider

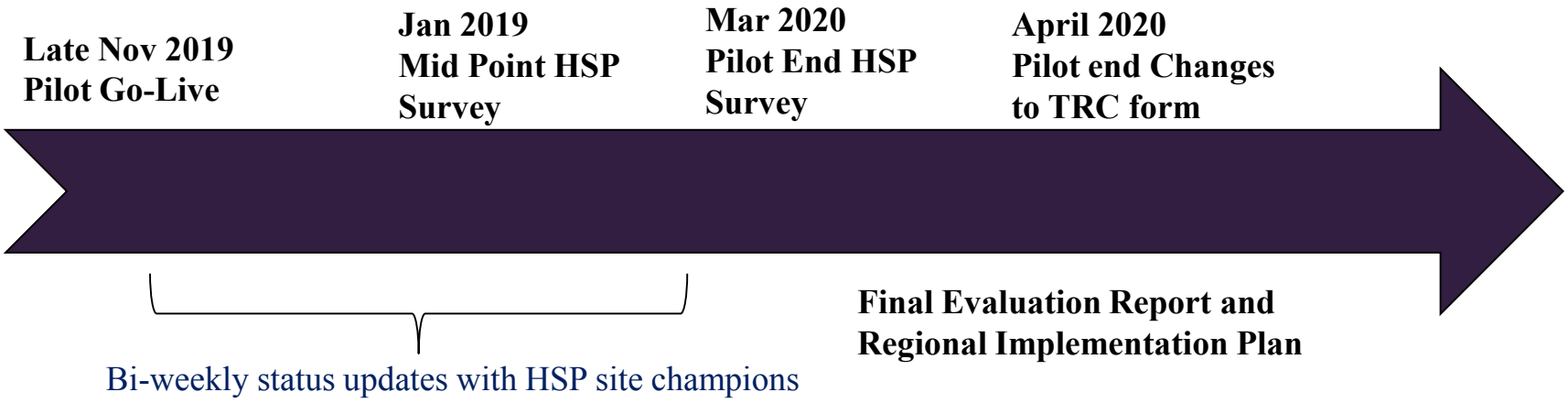
- Rehab goals met unmet
- If unmet, referral made to:
- Contact information

- Patient focus group to co design the patient form – June 17, 2019.
- Patient and Family reps from across the continuum of care provided feedback on what information they would like to see presented to them at time of discharge from a rehab provider.
- Separate engagement with Aphasia clients and caregivers

Evaluation

The TRC pilot evaluation will have two main objectives:

- Evaluate TRC content through mid pilot and pilot end surveys with participating HSP sites
- Evaluate improved rehab transitions through targeted patient surveys who have experienced at minimum 1 transition point



- **Patient Surveys:** will be administered through participating HSP/SPO sites at program discharge or within a week of discharge. A survey monkey link and paper version will be provided to participating sites . All surveys will be analyzed by the LHIN for final evaluation
- **HSP/SPO surveys:** (developed through survey monkey) will be provided to HSP site champions for completion. Results will be analyzed by the LHIN

Thank you for your attention!

Questions?

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