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SUBACUTE NAVIGATION:

INTEGRATED CONSULT AND EFFECTIVE TRANSITIONS

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AGENDA

- Welcome and Introductions
- Integrated Consult Initiative
- Rationale
- Process
- Strengths
- Effective Transitions
- Metrics
- Opportunities for Improvement
- Projects
- Questions/Comments

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SUBACUTE INTEGRATED CONSULT INITIATIVE

- Centralized model for facilitating timely, safe and efficient transitions from acute care to bedded subacute care
  - one-stop shopping

- Standardized process for referrals to subacute care using:
  - Provincial Resource Matching & Referral (RMR) form
  - Rehabilitation Decision Model

- Consult professionals at each tertiary care campus

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SUBACUTE INTEGRATED CONSULT INITIATIVE (CONT'D)

- includes referrals to the in-patient subacute sector:
  - The Ottawa Hospital Rehabilitation Centre
  - Short Term Rehab (The Ottawa Hospital General Campus)
  - Bruyère programs
    - Geriatric Rehab
    - Stroke Rehab
    - All Complex Continuing Care streams

    ****Exception: Palliative/Hospice beds*

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PARTNERS

- CURRENT:
  - Bruyère Continuing Care
  - Queensway-Carleton Hospital
  - Hôpital Montfort

- UPCOMING:
  - Small Hospitals

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TIMELINE

DATE	EVENT
November 2013	• small scale pilot at the Civic • referrals to TRC, Short Term Rehab and Geriatric Rehabilitation at Bruyère
December 2013	• Added CCC
2014-2015	• Full roll-out to all acute care units at both in-patient campuses
2015-2016	• Received Assess and Restore project funding
September 2015	• Added Stroke Rehab
November 2015	• QCH & Montfort Launch
January 2016	• Added Heart Institute • Added CCC consults from TRC • Initiating work with smaller hospitals • Leveraging e-referral work in small hospitals

RATIONALE

- Several previous attempts with limited success
- Multiple referrals to multiple services
- High volume of information sent between organizations to determine appropriateness for admission
- Need for efficient utilization of subacute services
- Improve access and timely transitions to subacute care
- Improve transition of care handovers

THEN

NOW

CENTRALIZED PROCESS

Team decision to refer for subacute navigation

Provincial RMR 1-pager completed and sent

Triaged using Rehabilitation Decision Model

Consult professional assesses patient

Patient is accepted/declined to best possible destination

Escalation process enabled when necessary

STANDARDIZING THE PROCESS: 1-PAGE REFERRAL

- Start of our transitions process
- Part of the Provincial RMR (Resource Matching and Referral) form
  - Provincial best practice for transition between sectors
  - Developed after lengthy consultation exercises across the province
  - Form content is prescribed with an aim to support seamless transfers between providers
- Gathered important elements into a 1-page referral form

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STANDARDIZING THE PROCESS: 1-PAGE REFERRAL (CONT'D)

Cluster 3 - Acute Care to Rehab & Complex Continuing Care (CCC) Referral

☐ Referral to Rehab or Complex Continuing Care (CCC) ☐ Referral to Physiatry (For opinion only)

Estimated Date of Rehab / CCC Readiness: DD/MM/YYYY

Patient Details and Demographics

First Name: ____ Last Name: ____ MRN #: ____

Date of Birth: DD/MM/YYYY Gender: ☐ M ☐ F ☐ Other Marital Status: ____

Primary Alternate Contact Person: ____

Relationship to Patient (Please check all applicable boxes): ☐POA ☐SDM ☐Spouse ☐Other

Telephone: ____ Alternate Telephone: ____ ☐ No Alternate Telephone

Room#: ____ Current Location Address: ____ Current Location Contact #: ____

Medical Information

Infection Control: ☐None ☐ MRSA ☐ VRE ☐ CDIFF ☐ TB ☐ ESBL ☐ Other: ____

Admission Date: DD/MM/YYYY Date of Injury / Event: DD/MM/YYYY Surgery Date: DD/MM/YYYY

Primary Diagnosis (Including Surgery if applicable):

History of Presenting Illness

Current Active Medical Issues / Medical Services Following Patient:

Baseline Functioning:

Current Functioning

Estimated length of Rehab

Patient Medical History:

Signature: ____ Professional Designation: ____ Date: ____

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STANDARDIZING THE PROCESS: REHABILITATION DECISION MODEL

- Supports triage to the best destination
- Developed by the physician group
- Extensive consultation
- Agreement between rehab destinations as to which patient profiles are best served by their unique expertise

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STANDARDIZING THE PROCESS: REHABILITATION DECISION MODEL (CONT'D)

REHABILITATION DECISION MODEL

April 10, 2013

Acute Care Course Completed

Patient Demonstrates Rehab Potential (Refer to Checklist)

Proceed to Subacute Referral Process (Rehab Destination)
For patients who do not meet the criteria for rehabilitation pathway, consider referring to the TOH Transitional Care Unit or to Restorative Care

Patient Medically Stable? (Refer to Checklist)

NO

Attending MD to Reassess

Is the Patient ≥ 65 y.o with any of the following:
- New or Unresolved Medical/Surgical Issue
- Cognitive Workup Required
- Unclear Discharge Trajectory

Consider Consulting Geriatric Medicine

YES

Identify the most appropriate rehabilitation service based on the following diagnosis (consultation will be required by the rehabilitation services):

ORTHO or VASCULAR

New Amputation

Consult TRC for Amputee Rehab

ORTHO AND TRAUMA

Joint Replacement

Criteria Care Map

Home

Consult STR

1-2 Limb Fractures (Hip, humerus/Wrist, Pelvic), Vertebral #, No Neuro compromise

≥ 75 y.o

Consult GRP

< 75 y.o

Consult STR

Complex Ortho (Multi-limb +/- Head + Spinal Injury, Multi-trauma, MVC)

Consult TRC for Complex Ortho Rehab

Spinal Decompression

≥ 80 y.o

Associated with significant comorbidities

Consult GRP

< 80 y.o

Consult STR

MEDICAL + SURGICAL

NEURO

Acute SCI (eg:. Trauma, Cancer)

Consult TRC for SCI Rehab

Acute TBI or ABI (eg: Cancer, SAH, SDH)

Consult TRC for ABI Rehab

Complex Neuro MS, ALS, AIDP/CIDP, MD, Spinal Stenosis with Neuro Compromise

Consult TRC for Complex Neuro Rehab

Acute Stroke Like Syndrome (Ischemia, Haemorrhage Cancer)

Consult using RITTS for Stroke Rehab

"Frail" Elderly
- Resolution of acute medical and surgical problems
- Vertebral or Pelvic fractures
- Falls
- Pre-existing neurological condition (e.g.: Parkinson's Disease)

≥ 65 y.o

Consult GRP

< 65 y.o

Consult STR

Complex Medical and Surgical Issues
- Solid Organ Transplant (Liver, Kidney)
- Burns
- Bariatric with Associated Deconditioning
- Deconditioning from Prolonged Acute Care Stay

Consult TRC Complex Ortho Rehab

Patient on Dialysis and Deconditioned

≥ 65 y.o

Consult CCC

< 65 y.o

Consult STR

Cancer (Not resulting in SCI, ABI, Stroke)
- Plan for home
- Modest Goals (Transfers, Equipt) to facilitate rapid discharge
- With concurrent oncology care

Consult STR

Legend

TRC = Rehab Centre
EB = Elizabeth Bruyere
SVP = Saint Vincent
GRP = Geriatric Rehab Program (EB)
GAU = Geriatric Assessment Unit
STR = Short Term rehab
SDH = Subdural Hemorrhage

RITTS = Web Based Stroke Rehab Application
MVC = Motor Vehicle Collision
SCI = Spinal Cord Injury
ABI = Acquired Brain Injury
TBI = Traumatic Brain Injury
CCC = Complex Continuing Care
SAH = Subarachnoid Hemorrhage

TRANSITIONS: ROLE OF THE INTEGRATED CONSULT TEAM

- Triage guided by Rehab Decision Model to the most appropriate service
- Complete assessment
  - Thorough chart review
  - Meet with and observe patient
  - Case consultation as required
  - Complete provincial RMR form
- Review cases with physicians from subacute destinations as needed
- Document acceptance/refusal information
- Liaise with subacute destination and forward necessary chart documentation

STRENGTHS

- Single point of access
- 1-page referral
- Streamlined process
- Standardized
- Referred patients seen by a consult professional within 24 hours of referral
- Liaison between consult professional and subacute destination for improved communication and transition

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REFERRAL VOLUMES

REFERRAL VOLUMES

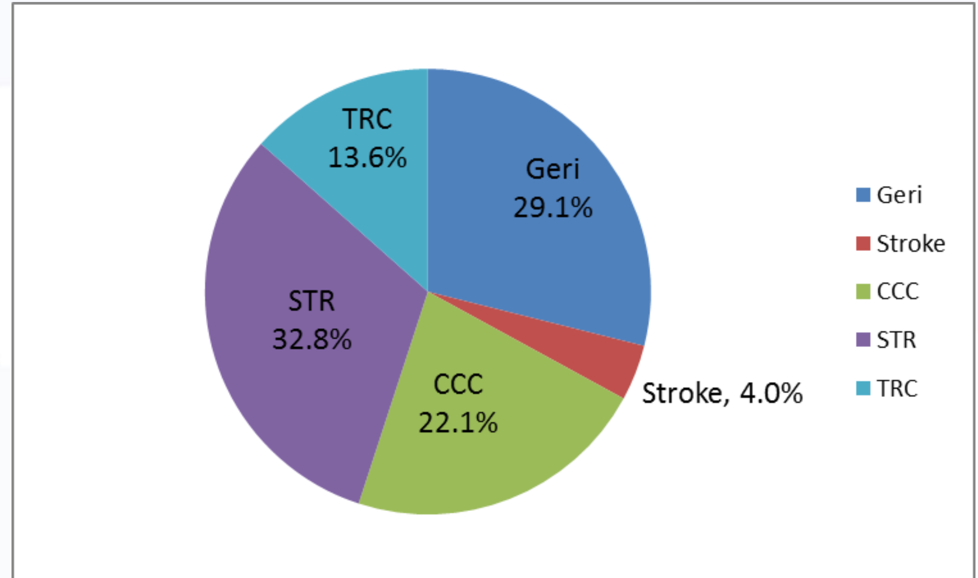
- Referral volumes increasing overall
- Overall increase of 35%
- Q4 is on track for a 15% increase if volumes hold
- All destinations are increasing at the same relative rate

Quarter	Number of Consults
Q4 14-15	418
Q1 15-16	495
Q2 15-16	537
Q3 15-16	645

REFERRAL DISTRIBUTION

- STR, Geri and CCC represent largest referral volumes
- Stroke volume was initially small with gradual roll-out in Q2
  - Expected to increase

REFERRAL DISTRIBUTION



TURN-AROUND TIME: TRIAGE TO DECISION

Q1 15-16

Triage to Decision	Gerl	Stroke	CCC	STR	TRC
≤ 24 hrs	**84.7%**	**0.0%**	**55.7%**	**77.9%**	**47.9%**
2-3 days	11.1%	0.0%	21.7%	12.2%	24.7%
≥ 4 days	4.2%	0.0%	22.6%	9.9%	27.4%

Q2 15-16

Triage to Decision	Geri	Stroke	CCC	STR	TRC
≤ 24 hrs	**91.4%**	**80.8%**	**42.1%**	**74.2%**	**50.7%**
2-3 days	4.6%	11.5%	24.3%	14.0%	13.3%
≥ 4 days	4.0%	7.7%	33.6%	11.8%	36.0%

Q3 15-16

Triage to Decision	Geri	Stroke	CCC	STR	TRC
≤ 24 hrs	**86.4%**	**80.4%**	**48.1%**	**71.6%**	**59.2%**
2-3 days	10.1%	12.5%	27.9%	14.2%	29.6%
≥ 4 days	3.6%	7.1%	24.0%	14.2%	11.3%

TURN-AROUND TIME: TARGET SETTING

- Initiated target setting for turn-around times within 24 hours of triage
- An additional consult professional has been trained in STR to assist with referral volumes
- CCC targets TBD

TURN-AROUND TIME: TARGET SETTING

	F15/16			
	Q1	Q2	Q3	Q4 TO DATE
Geri Target: 85% Stretch: 90%	84.7	91.4	86.4	92
Stroke Target: 80% Stretch: 85%		80.8	80.4	93
TRC Target: 65% Stretch: 70%	47.9	50.7	59.2	65
STR Target: 75% Stretch: 80%	77.9	74.2	71.6	71

Legend		
	Purple	Exceeds target ≥ 5% (Stretch target or greater)
	Green	At target-4% above target
	Yellow	1-4% below target
	Red	≥ 5% below target

NEXT STEPS

- Improving consult professional “silos”
  - ➢ Cross-training to ensure consult professionals can assess for multiple destinations
- Streamlining processes with TRC referral process
- Appropriate triage decision
  - ➢ Education to referring units for completeness of referral
- Improving processes for waitlisted patients to move to next best rehab destination
- Referral and tracking accuracy
  - ➢ Tracking and trending consult volumes and turn-around times
  - ➢ Leverage e-referral work in progress at small hospitals

LHIN PROJECT UPDATES: QUEENSWAY-CARLETON HOSPITAL

- Streamlining processes with a focus on Bruyère rehab and CCC destinations
- Rolled out November 9, 2015
- Rehab Decision Model was adapted to meet QCH's processes and programs
- Successes
  - Improved understanding within QCH of Bruyère destinations
  - Smoother flow to Bruyère
  - Decision time is now within 1-2 days of referral

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LHIN PROJECT UPDATES: HOPITAL MONTFORT

- Adapt Meditech to enable electronic RMR form
- Adapt Rehab Decision Model to meet Montfort's processes and programs
- Map the referral process flow
- Next Steps:
  - Implement changes within Meditech and educate staff
  - Discuss changes with other Meditech hospitals
  - Collaborate with leveraging the work done in small hospitals on ereferral
  - Work with TRC to smooth referral processes

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LHIN PROJECT UPDATES: LEVERAGING eREFERRAL WORK IN SMALL HOSPITALS

- work has been done between Almonte and Carleton Place to refer via SharePoint collaboration space
- Generated much interest
- Leveraging and expanding this process to other hospitals within the LHIN
- Leveraging Montfort's work on Meditech to determine if this can function in conjunction with SharePoint ereferral process

QUESTIONS / COMMENTS

APPENDIX 1: PROCESS MAP