CHANGE PACKAGE OVERVIEW

Proposed New Referral Process Hip Fracture Initiative

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Table of Contents

Section 1: Change Package 3
  1.1. What is a Change Package 3
  1.2. Purpose of the Change Package for the Proposed New Referral Process Hip Fracture Initiative 3

Section 2: Spreading Effective Change 4
  2.1. Background 4
    2.1.1. Cross Sector Hip Fracture Task Group 4
    2.1.2. IDEAS Project Initiative 5
      2.1.2.1. AIM Statement of IDEAS Project Team 5
      2.1.2.2. Change Ideas 5
      2.1.2.3. Family of Measures 6
    2.1.3. UHN LEAN Initiative for Hip Fracture 7
      2.1.3.1. Goal of the UHN Team LEAN Initiative 7
      2.1.3.2. Change Ideas 7

Section 3: Proposed New Referral Process Hip Fracture Initiative 9
  3.1. Proposed AIM Statement 9
  3.1.1. Problem Identification 9
  3.2. Proposed Implementation Model 9
  3.3. Proposed Measures 9
    3.3.1. Proposed Process Measures 9
    3.3.2. Proposed Outcome Measures 9
    3.3.3. Proposed Balancing Measures 9
  3.3.4. Data Collection Template 10
  3.4. Tools Developed by the Cross Sector Task Group to Support the Proposed New Referral Process Hip Fracture Initiative 10
    3.4.1. Admission Criteria Guidelines 10
    3.4.2. Rehab Application (RM&R) Cheat Sheet 10
    3.4.3. Rehab Referral Considerations 10
    3.4.4. Patient Transition Education Brochure for Hip Fracture (Draft) 10

Section 4: Roles and Responsibilities 12
  4.1. Roles and Responsibilities of the GTA Rehab Network 12
  4.2. Roles and Responsibilities of Key Leads of Participating Organizations 12

Section 5: Proposed Next Steps in Implementing the New Referral Process Hip Fracture Initiative 13
Section 1: Change Package

1.1. What is a Change Package

A change package consists of a number of high-level outcomes supported by evidence-based concepts and change ideas that, when implemented, bring about quality improvement. A change package is created to capture what is known about best practices and processes based on evidence from literature, research, and the experiences of others.¹

1.2. Purpose of the Change Package for the Proposed New Referral Process Hip Fracture Initiative

A change idea² is an actionable, specific idea for changing a process. Change ideas can come from research, best practices, or from other organizations that have recognized a problem and have demonstrated improvement on a specific issue.

The Change Package for the Proposed New Referral Process Hip Fracture Initiative³ was developed to describe the early referral initiatives, common principles and the implemented change idea of
- Toronto East General Hospital (TEGH), Bridgepoint Active Healthcare – Sinai Health System, Providence Healthcare and the GTA Rehab Network (referred as the Improving and Driving Excellence Across Sectors [IDEAS] project team henceforth)
- University Health Network (UHN): Toronto Western Hospital - Toronto Rehab LEAN initiative
to improve patient transitions from acute care to inpatient rehabilitation. This package was developed as background information for the March 9, 2015 Hip Fracture Forum.

In addition, the Change Package describes the Proposed New Referral Process Hip Fracture Initiative and the tools developed by the Cross Sector Hip Fracture Task Group and GTA Rehab Network to support this initiative.

³ New Referral Process Hip Fracture Initiative was the terminology agreed upon by the GTA Rehab Network Cross Sector Hip Fracture Task Group to describe transitioning patients as early as possible from acute care to inpatient rehabilitation/Low Tolerance Long Duration (LTLD) rehabilitation programs.
Section 2:  Spreading Effective Change

2.1. Background

In 2013, Health Quality Ontario (HQO) released a Clinical Handbook for Quality-Based Procedures with recommended practices for Hip Fracture. The concept behind the Proposed New Referral Process Hip Fracture Initiative was based on HQO’s recommendation that hospital care pathways should adopt the goal of active rehabilitation commencing no later than day 6 following the patient’s surgery [with a focus on rehabilitation in post-acute settings]. It was recommended that all hip fracture patients receive an active rehabilitation program following their acute care stay. The location where the rehabilitation program is provided may occur in different settings including inpatient rehabilitation and complex continuing care, and community-based settings such as rehabilitation in the home or through outpatient physiotherapy clinics. HQO found that there was insufficient evidence to indicate what the optimal timing to begin rehabilitation is after conducting a rapid review of the literature. In lieu of this, the post-operative day 6 target was adopted from the National Hip Fracture Toolkit by HQO.

2.1.1. Cross Sector Hip Fracture Task Group

The GTA Rehab Network convened the Cross Sector Hip Fracture Task Group in May 2014 and invited Network members to identify health system strategic initiatives for hip fracture to improve patient transitions from acute care to inpatient rehabilitation, low tolerance long duration (LTLD) rehabilitation programs and convalescent care, and implement recommended practices related to rehabilitative care across the continuum.

Lessons learned from two known organizational initiatives (i.e., IDEAS project and UHN LEAN initiative) focusing on improving patient transition from acute care to inpatient rehabilitation for patients post-hip fracture were shared with task group members. Both initiatives shared the common concept of early patient referral from acute care to inpatient rehabilitation to achieve their goals. Shared principles between the two initiatives also included:

- Early completion of rehab referral by acute care clinicians
- Consideration of the patient’s premorbid functional status and psychosocial status in making a decision on a rehab application. This is a recognition that patient’s functional status during the first few days post-surgery will be at a lower functional level, and as such, is not a good indicator of restorative potential.
- Timely response to the application by the receiving rehabilitation program

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• Building trust amongst acute care and rehab teams through regular communication: This included understanding and respecting the processes and challenges that their cross-sector partners face in day to day service provision.

The cross sector task group members expressed interest in working on improving patient transition from acute care to inpatient rehab as a health system initiative, and integrating the lessons learned from the IDEAS project team and UHN team. The shared concept from the two initiatives of early patient referral was named as the ‘New Referral Process Hip Fracture Initiative’ by the task group. The task group, supported by the GTA Rehab Network, also developed tools to support this initiative that are included in this document.

The GTA Rehab Network asked organizations participating in the New Referral Process Hip Fracture Initiative to identify a key project lead for each organization. The key leads of participating organizations are listed in Appendix A.

2.1.2. IDEAS Project Initiative
Toronto East General Hospital (TEGH), Bridgepoint Active Healthcare – Sinai Health System, Providence Healthcare and the GTA Rehab Network worked as a team to implement a quality improvement project on ‘improving transitions to external rehab for fractured hip patients’. This applied learning project was initiated in Spring 2014 and was part of the IDEAS program, supported by a quality improvement advisor from HQO.

2.1.2.1. AIM Statement of IDEAS Project Team
The project AIM of the IDEAS project team was to reduce the current average ALC days for TEGH fractured hip patients referred to Providence and Bridgepoint from 4.42 days to 3 days by October 1, 2014.

The overall AIM was to reduce the total average length of stay (LOS) from 7 days acute, 3.5 days ALC (total 10.5 days) to 6 days acute, 1.8 days ALC (total 7.8 days) by focusing on improving transition time to rehab by December 2015.

2.1.2.2. Change Ideas
Acute Care Change Ideas

Completion of rehab referral application by post-op day 1-2.

Sending completed rehab referral to appropriate inpatient rehab/LTLD rehab programs by post-op day 1-2.
Inpatient Rehab/LTLD Rehab Change Ideas

**Rehab Application Review:** Consider patient’s pre-morbid level of function and psychosocial status to determine response to application

**Respond to acute care within 1 day of receiving rehab referral application with the assumption that patient is medically stable or is expected to become medically stable by a specified date**

**Other acute care change ideas that supported the project AIM**

To support the overall AIM and project AIM, the TEGH acute care team also embarked on other quality improvement processes:

- Improvement of access to surgery within 48 hours of admission
- Determine the need for pre-op cardiology consult and implementation of recommended guidelines for echocardiogram testing
- Implementation of standardized risk assessment tool (i.e., Blaylock Discharge Planning Risk Assessment Screen) on admission to facilitate discharge planning
- Revision of hip fracture order sets
- Review and evaluation of post-op pathways (i.e., establishing criteria for ICU admissions)
- Create processes to enable 7 day/week discharge processes (work in progress)

2.1.2.3. **Family of Measures**

- **Process Measures:**
  - % of total patients post-hip fracture that have an early referral response from Providence and/or Bridgepoint within target of 1 day
  - % of patients transferred to Bridgepoint/Providence within 3 days of ALC designation

- **Outcome Measures:**
  - Average total of ALC days to external rehab ≤ 3 days for Bridgepoint and Providence

- **Balancing Measures:**
  - % of patients readmitted back to acute care/Emergency from Providence and/or Bridgepoint within 30 days post-op
  - % of patients that expressed satisfaction with their transition to rehab from TEGH
  - Clinical outcomes and length of stay following inpatient rehab stay
2.1.3. **UHN LEAN Initiative for Hip Fracture**

In the Fall of 2013, the Toronto Western Hospital and the Toronto Rehab musculoskeletal program of the University Health Network embarked on a LEAN rapid improvement initiative for patients post-hip fracture.

2.1.3.1. **Goal of the UHN Team LEAN Initiative**

The main goal for the rapid improvement initiative of the UHN Team related to improving patient transition from acute care to inpatient rehab for fractured hip patients was to standardize processes to allow all patients to transfer to inpatient rehab by post-operative day 5.

2.1.3.2. **Change Ideas**

**Acute Care Change Ideas**

- Initiate rehab referral pre-op (i.e., complete pre-morbid functional status, social and medical history) in RM&R, if possible
- Send completed referral to appropriate programs when patient is medically manageable in inpatient rehab/LTLD rehab

**Inpatient Rehab Change Ideas**

- Rehab Application Review: Consider patient’s pre-morbid level of function and psychosocial status to determine response to application
- Respond to acute care within 1 day of receiving rehab referral application

**Other processes that supported achievement of goal**

Processes implemented by the UHN team to support the achievement of the process improvement goal included the following:

- Created transparency to the patient transfer process. Established "one program" thinking between Toronto Western Hospital orthopedic inpatient program and Toronto Rehab musculoskeletal program, instead of acute and rehab
- Reduced rework by establishing standard processes and definitions.
  - Standardized definition of "Medically Manageable". No separate definition of "Rehab Ready".
- Standardized new acute triage of appropriate rehab candidate, referral, and acute stay processes for a common understanding what should be happening
- Standard measurement plan to see if processes are working and where the standards can be improved
- Standard process for geriatric assessment follow-up once patient is ready to transfer to Toronto Rehab - musculoskeletal program from Toronto Western Hospital
- Standard process for alerting Toronto Rehab - musculoskeletal program to new hip fracture referrals to allow timely response and increase transfers
  - Developed guidelines to ensure all follow-up tests and consults are arranged prior to transfer
  - Appropriate medical information added to referrals
  - Daily management process to sustain the improvements and adapt to changes (i.e. huddles)
Section 3: Proposed New Referral Process Hip Fracture Initiative

3.1. Proposed AIM Statement

To standardize and enhance access to rehabilitation post-surgery for patients post-hip fracture across participating hospitals, with the goal of reducing the acute care length of stay from surgery to discharge (to inpatient rehab/LTLD rehab programs) to an average of 6 days by January 2016.

The proposed AIM statement was based on the recommendation of HQO that hospital care pathways should adopt the goal of active rehabilitation commencing no later than day 6 following the patient’s surgery. The ability to achieve the goal of January 2016 will depend on the baseline performance of each acute care organization.

3.1.1. Problem Identification

Based on a 7-week period of snapshot data of hip fracture referrals from 7 acute care organizations conducted by the GTA Rehab Network in 2013-14 FY, the average length of time from surgery to discharge in acute care was 10 days (median 8 days), which was longer than HQO’s recommendation that active rehabilitation in post-acute setting should commence by day 6. The average length of time from surgery to date referral was sent was 7 days (median 6 days).

3.2. Proposed Implementation Model

A draft model of the Proposed New Referral Process Hip Fracture Initiative outlines the processes of the IDEAS project team (Option A Pathway) and the UHN team LEAN initiative (Option B Pathway). This model was drafted for participating organizations to consider and decide which change idea(s) to adopt/adapt. (See Appendix B)

3.3. Proposed Measures

3.3.1. Proposed Process Measures

- % of total patients post-hip fracture with referrals sent by post-op day 1-3 to inpatient rehab/LTLD rehab programs by January 2016
- % of total referrals received by inpatient rehab/LTLD rehab programs with a 1-day rehab response time by January 2016

3.3.2. Proposed Outcome Measures

- Average length of stay from surgery to discharge to inpatient rehab/LTLD rehab programs by January 2016

3.3.3. Proposed Balancing Measures

- % of patients readmitted back to acute care/Emergency from inpatient rehab/LTLD rehab within 30 days post-op
3.3.4. **Data Collection Template**
In order to measure the adoption of the change ideas selected by participating organizations, the acute care programs need to collect referral process indicators and inpatient rehab/LTLD rehab programs need to collect their responses to referrals. A proposed data collection implementation template for referral processes from acute care to inpatient rehab/LTLD rehab is attached in Appendix C. The proposed template also includes weekend discharge indicators for acute care and weekend admission indicators for inpatient rehab/LTLD rehab.

This proposed data collection implementation template is the version used during baseline data collection and may be revised based on feedback from users’ experiences during baseline data collection phase.

3.4. **Tools Developed by the Cross Sector Task Group to Support the Proposed New Referral Process Hip Fracture Initiative**

3.4.1. **Admission Criteria Guidelines**
This document was developed by the Rehab/LTLD rehab working group of the Cross Sector Hip Fracture Task Group at the request of acute care members to clarify patient needs that are medically manageable criteria in rehab/LTLD rehab. The document also provides an overview of information needed when completing rehab applications and rationale of the need for this information to facilitate understanding across sectors. *(See Appendix D)*

3.4.2. **Rehab Application (RM&R) Cheat Sheet**
Some of the information in the Admission Criteria Guideline document was reformatted as a tool for clinicians completing rehab applications. The purpose of the document was to minimize requests for information (RFI) during the application process that delay the rehab application and transition processes. *(See Appendix E)*

3.4.3. **Rehab Referral Considerations**
This document outlined criteria or conditions that required more consideration during the rehab application process that may not follow the pathway(s) recommended in the Proposed New Referral Process Hip Fracture Initiative. *(See Appendix F)*

3.4.4. **Patient Transition Education Brochure for Hip Fracture (Draft)**
This brochure titled ‘Planning for your in-hospital stay in rehab following a hip fracture’ was developed for the purpose of communicating expectations to patients and caregivers consistently across all settings. The goal is to provide this brochure at the earliest point of entry along the continuum (i.e., in acute care) when consent is obtained to apply to an
inpatient rehab/LTLD rehab program. Feedback from task group members and two patient advisory groups from North York General Hospital and Credit Valley Hospital – Trillium Health Partners was integrated to develop this tool. (See Appendix G)
Section 4: Roles and Responsibilities

4.1. Roles and Responsibilities of the GTA Rehab Network

The following are the roles and responsibilities of the GTA Rehab Network in facilitating the adoption of the New Referral Process Hip Fracture Initiative:

- Planning, communication follow-up and supporting participating organizations that are ready to adopt/adapt change ideas (e.g., defining project timelines).
- Hosting regular meetings and coordinating with the key leads of participating organizations to support communications across organizations
  - Facilitate participating organizations to share their stories: challenges, successes and solutions in implementation (i.e., facilitating knowledge exchange opportunities)
- Providing guidance on quality improvement approaches
- Developing and disseminating tools
- Integrating project learnings and revising resources/tools as needed
- Providing data analysis support for participating organizations
  - Communication and update of progress with data – timeframe to be determined
- Defining roles and responsibilities of participating organizations

4.2. Roles and Responsibilities of Key Leads of Participating Organizations

The following are the roles and responsibilities identified for key leads of participating organizations:

- **Working and informing leadership and clinical team members of their organization of the initiative and proposed implementation plans:**
  - The lead(s) will be responsible in working with his/her manager or program director as well as clinical team members who complete referral applications for patients post-hip fracture:
    - To explore with management team re: other processes assessment that may become a barrier in the successful implementation of the new referral process initiative for hip fracture
    - To educate with his/her team of the details of the implementation plan, and tools developed to support this initiative
    - To facilitate change management within his/her clinical team members (e.g., target completion and sending of referrals, use of RM&R cheat sheet in completing application)
    - To facilitate identification of what worked well and areas to improve during the quality improvement cycle
    - To facilitate communication with partnership organization(s).
- **Performance metrics (data indicator) collection and monitoring:**
  - The lead(s) will be responsible to obtain the required performance metrics for his/her organization as part of the quality improvement initiative. This may involve working with decision support/data management teams of the organization and/or clinical/administrative staff to collect data during the quality improvement implementation cycle. Once the organizations adopt/implement change idea(s), the lead(s) will also be responsible in monitoring completion of initial referral process data collection.
Section 5: Proposed Next Steps in Implementing the New Referral Process Hip Fracture Initiative

The following section is a proposed checklist and timeline for participating organization in preparation for implementation of the New Referral Process Hip Fracture Initiative.

Mid-March 2015 to mid-April 2015

- Identify the designated key project lead(s) for your organization (if not yet identified)
- Confirm any partnership(s) that have not been solidified
- Identify an executive sponsor for this initiative for your organization
- Identify key stakeholders for this initiative
- Complete readiness to receive assessment *(Appendix H)*

Mid-April 2015 to end of May 2015

- Project teams participate in webinar session on ‘Defining the problem’ (use of QI tools), clarify data collection expectations
- Complete the quality improvement tools provided by Health Quality Ontario to confirm directions for implementation amongst members of your team.
- Start development of organizational project charter. A sample drafted was attached in *Appendix I.*
- Set timelines to achieve overall AIM for each participating organization and confirm commitment from relevant stakeholders

June 2015

- Discuss which change idea(s)/pathway work best for your team. Consider your baseline data and the completed ‘readiness to receive self-assessment’ to assist with your decision.
- Discuss with your partner organization(s), which change idea(s)/pathway work for them
- Finalize the change idea(s)/pathway your organization will adopt/adapt
- Share findings and celebrate early project learnings
- Complete project charter with executive sponsor sign-off
July 2015 to December 2015

Implement adoption of change idea pathway

As organizations progress in identifying their state of readiness to implement the change ideas, the GTA Rehab Network will continue to support organizations with further defining project timelines, provision of tools, information, data analysis and knowledge exchange opportunities.

The GTA Rehab Network would like to thank the HQO Quality Improvement team, the IDEAS Project Team and the UHN LEAN Initiative Team for their guidance and feedback in the development of this change package document. In addition, the GTA Rehab Network extends its appreciation to members of the Cross Sector Hip Fracture Task Group for their support in developing the tools to support the proposed new referral process hip fracture initiative.