CHANGE PACKAGE OVERVIEW

New Referral Process Hip Fracture Initiative

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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 New Referral Process Hip Fracture Initiative³ was developed to describe the early referral initiatives, common principles and the implemented change idea of

- Michael Garron Hospital, 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 originally developed as background information for the March 9, 2015 Hip Fracture Forum.

In addition, the Change Package describes the 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.

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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\(^4\) with recommended practices for Hip Fracture. The concept behind the 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]. This recommendation is consistent with evidence that early access to an inpatient rehabilitation program post-hip fracture increases the likelihood of patients returning home.\(^5\)

HQO also 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\(^6\) 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

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\(^5\) Canadian Institute of Health Information (CIHI). 2015. Factors predicting return home from inpatient rehabilitation following hip fracture surgery. Ottawa: CIHI. Available from:

• Consideration of the patient’s premorbid functional status and psychosocial status in making a decision on a rehab application. This is 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

• 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
Michael Garron Hospital, 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 Michael Garron Hospital’s 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 Michael Garron Hospital’s 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 Michael Garron Hospital
- 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

Completion of rehab referral application by post-op day 1-3.

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

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: New Referral Process Hip Fracture Initiative

3.1. 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 programs) to an average of 6 days by December 2016.

The 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 by December 2016 (for rehab discharges) will depend on the baseline performance of each acute care organization.

Although discharges to LTLD rehab programs from acute care did not have an identified average length of stay goal, participating hospitals indicated interest in applying the early referral model where possible to improve their referral processes.

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. Implementation Model

The model of the 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. Measures

3.3.1. Process Measures

- % of total patients post-hip fracture with referrals sent by post-op day 1-3 to inpatient rehab/LTLD rehab programs by June 2016 (Pathway A)
- % of total referrals received by inpatient rehab/LTLD rehab programs with a 1-day rehab response time by January 2016
- % of referrals offered weekend beds by inpatient rehab/LTLD rehab for patients post-hip fracture within partnership
- % of weekend admissions to inpatient rehab/LTLD rehab for patients post-hip fracture within partnership
- % of Request for Information (RFI) and reasons for RFI
3.3.2. Outcome Measures

- % of Declined Referrals and reasons for declined referrals

- Average length of stay from surgery to discharge to inpatient rehab programs by December 2016

3.3.3. Balancing Measures

- % of patients readmitted back to acute care (service interruption and unplanned discharges)
- Clinical outcome using FIM following inpatient rehab program (average admission FIM score, average discharge FIM score, average FIM change score, FIM efficiency)
- Length of stay during inpatient rehab/LTLD rehab program
- Discharge destinations from inpatient rehab/LTLD rehab program
- Survey of patient experience related to the acute care to rehab transition
- Feedback (qualitative) from project leads/teams of participating organizations regarding the experience of being part of the initiative and its impact on their organization

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 data collection implementation template for referral processes from acute care to inpatient rehab/LTLD rehab was developed with the project leads based on data elements which facilitate identification of potential issues in referral processes. The template also included weekend discharge indicators for acute care and weekend admission indicators for inpatient rehab/LTLD rehab.

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 C)

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 D)
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 New Referral Process Hip Fracture Initiative. (See Appendix E)

3.4.4. Patient Transition Education Brochure for Hip Fracture
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 were integrated to develop this tool. (See Appendix F)
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 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 involves 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: Key Milestones and Next Steps in Implementing the New Referral Process Hip Fracture Initiative

5.1. Key Milestones
The following section outlines key milestones achieved by participating organizations of the New Referral Process Hip Fracture Initiative.

March to May 2015
- March 9th Hip Fracture Forum: The GTA Rehab Network convened interested stakeholders to introduce the New Referral Process Hip Fracture Initiative. Health Quality Ontario quality improvement team provided education on quality improvement foundational concepts and tools to facilitate implementation.
- Interested organizations identified project lead(s) (if not yet identified).
- Interested organizations confirmed any cross-sectoral partnership(s) that had not been confirmed.
- Project teams of interested organizations completed the Readiness to Receive Assessment.
- Participating organizations identified an executive sponsor.

June 2015 to September 2016
- GTA Rehab Network and project leads developed a shared Project Charter.
- Participating partnership organizations confirmed the change idea pathway(s) to be adopted/adapted.
- Executive sponsor sign-off of Project Charter was submitted to GTA Rehab Network to confirm participation and organizational commitment.
- Project teams (cohort 1) implemented change idea pathway(s) and started collecting referral process data after their change process implementation (Spring/Fall 2015).
- The IDEAS project team received the IDEAS Alumni Award Fund (October 2015).
- GTA Rehab Network hosted a second Hip Fracture Forum: Early adopters shared their successes and project learnings with stakeholders (November 2015)
- Patient experience questionnaires administered and completed (winter 2016).
- An Analyst, funded from the IDEAS Alumni Award, was recruited to support analysis of referral process data for quality improvement (March 2016 – September 2016).
- Project teams (cohort 2) implemented change idea pathway(s) and started collecting referral process data after their change process implementation (May 2016 to September 2016)
- Evaluation of project and performance of participating organizations in implementing the New Referral Process for Hip Fracture (July 2016)

The GTA Rehab Network Project Manager and Analyst continue working with each partnership to review their progress using the latest referral process data and apply their learnings using repeated Plan-Do-Study-Act (PDSA) change cycles.

October 2016 to December 2016

- Project teams (cohort 1) that were ready transitioned to ‘audit’ phase in collecting referral process data
- The GTA Rehab Network coordinated meetings with project sponsors/leads of each cohort 1 partnership to (a) update teams’ progress (b) provide recommended practices to sustain project teams’ achievements. Recommendations include continuation of regular partnership meetings, using case review approach to identify referral process delays, involving decision support to monitor ongoing performance.

5.2. Next Steps

The GTA Rehab Network Project Manager will continue working with
- Cohort 1 partnership during the referral process audit phase, and
- Cohort 2 partnership to analyze results of their change process implementation, facilitate partnership meetings to identify referral process issues and solutions for quality improvement.

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.