GTA REHAB Network

Discussion Document

Developing a Performance Framework for Outpatient Rehabilitation

February 2013

Introduction

Background

The GTA Rehab Network and others, including the Ontario Ministry of Health and Long Term Care and other national stakeholders, have identified a need for data on outpatient rehabilitation services. Clinical decision makers have long expressed interest in evaluating outpatient rehabilitation, particularly given the reported erosion of outpatient rehab services in the Greater Toronto Area (GTA) over the last 10 years[1] and observed access issues.[2 3 4] The need for data is also linked to a renewed focus on understanding the role of outpatient rehabilitation within an integrated and efficient healthcare system.

An understanding of performance across outpatient rehabilitation programs will benefit stakeholders by informing long term planning and evaluation at the program and organizational levels. Consistent use of comparable performance metrics will also support an understanding of the role of outpatient rehabilitation in supporting other aspects of hospital and community based services.

There is a gap, however, in the availability and consistency of data across outpatient rehabilitation programs. There is no known mandated provincial or national-level reporting of outpatient rehabilitation data. While the National Ambulatory Care Reporting System (NACRS), does report standardized ambulatory data, it includes only hospital based clinic visits, not outpatient rehabilitation programs. No guidelines exist for hospital-based outpatient reporting to a CIHI standardized patient classification system. Consequently, important clinical information related to individual services delivered, service volumes, or the level of rehab intensity, is absent from the Ministry's data holdings.[5] Thus, attempts to evaluate the performance of outpatient rehabilitation programs tend to be localized, limiting comparisons across programs or across the continuum.

Given the importance of reliable data to inform decision-making and evaluate performance, the GTA Rehab Network has drafted the following performance framework for measurement of outpatient rehabilitation programs and services. The framework is intended to serve as a basis for discussion with provincial and possibly national stakeholders on key indicators for collection and reporting of outpatient rehabilitation data. The intent is to achieve a balance between the collection of information to meet evaluation objectives and the time and resources required to collect, analyze and report the information.

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[1] Seo, H. & Levy, C. (2011). Outpatient Rehabilitation in the GTA: Understanding the Current State. Final Report. Toronto, Ontario: GTA Rehab Network. http://www.gtarehabnetwork.ca/uploads/File/reports/report-outpatientrehab-june2011.pdf

[2] Landry, M.D., Deber, R.B., Jaglal, S., Laporte, A., Holyoke, P., Devitt, R., & Cott, C. (2006). Assessing the consequences of delisting publicly funded community-based physical therapy on self-reported health in Ontario, Canada: A prospective cohort study. *International Journal of Rehabilitation Research, 29*(4): 303-307.

[3] Passalent, L.A., Landry, M.D., & Cott, C. (2010). Exploring wait list prioritization and management strategies for publicly-funded ambulatory rehabilitation services in Ontario, Canada: Further evidence of barriers to access for people with chronic disease. *Healthcare Policy, 5,* 4, e139-e156.

[4] Landry, M.D., Passalent, L.A., & Cott, C. (2009). Wait times for publicly-funded outpatient or community physiotherapy and occupational therapy services: Implications for the increasing number of persons with chronic conditions in Ontario, Canada. *Physiotherapy Canada, 61,* 5-14.

[5] Alvarez, Rene, MOHLTC. Presentation October 18, 2012.

Considerations

In developing a performance framework for outpatient rehabilitation, the following considerations are outlined in this document and will need to be discussed and validated with stakeholders prior to implementation:

1. Confirm the overall objective(s) in developing performance metrics for outpatient rehabilitation
2. Consider the conceptual framework that will guide the development of performance metrics
3. Consider the frequency of and how the data will be captured, analyzed and reported
4. Confirm the definitions for what outpatient rehabilitation data/information will be captured, including both specific indicators and rehabilitation program/service types, i.e.,

    a. Single or multidisciplinary programs; supportive services and timing of rehab post acute-injury/illness.
    b. Hospital based or hospital governed clinics, OHIP clinics, CCAC governed congregate clinics, other
    c. More consistent and applicable definitions beyond the current utilization of visits and attendances (see appendix) will need to be identified.

5. Consider the specific metrics to be included in the framework, taking into account the overall objectives balanced with practical implementation.
6. Consider comparability across various program models, i.e., comparison across programs within and across organizations and across populations served and analysis of data across quadrants.
7. Consider process for establishment of targets/benchmarks, i.e., for wait time, patient volumes, therapy intensity, etc.
8. Consider the training, resources, tools, and engagement that are required to successfully test and implement the framework.

Programs will need to use standardized tools for scoring on admission and discharge. To enhance the potential for comparability across populations, global scales may be considered including: Goal Attainment Scale (GAS), Community Integration Questionnaire (CIQ), Return to Normal Living Index (RNLI), Measure of Process of Care (MPOC), and Canadian Occupational Performance Measure (COPM). Use of the FIM follow up tool may also be considered to provide consistency in measurement across programs.

Measurement of clinical outcomes across rehab populations is expected to be the most challenging aspect to measure, report and compare. There is a need to consider if all 4 performance quadrants will be consistently applied across all populations or if the clinical outcome quadrant will differ depending on the rehab population.

The benefits in using a global measurement tool to enhance comparability will need to be weighed against the lack of sensitivity and specificity in the measurement of more clinically focused and population specific outcomes.

Objective in Measurement of Outpatient Rehabilitation Programs/Services

To collect a minimum dataset in a standardized format on Ministry-funded outpatient rehabilitation programs (i.e. hospital-based outpatient rehab programs funded through the global budget; CCAC congregate rehab clinics; and OHIP funded Physiotherapy clinics). The standardized data will be used to measure clinical and administrative performance across rehabilitation programs and services to inform planning and service provision.

Options	OUTPATIENT PROGRAM ANALYSIS	SYSTEM ANALYSIS
Questions that could be answered	• What are the benefits of outpatient rehabilitation? Consider the perspectives of: - Patient Experience - Clinical Outcome - Financial Measures • What are the utilization rates for outpatient rehabilitation across conditions? • How does program X compare to similar programs? • Is there a model of service delivery that correlates with improved performance?	• What are the relative costs of outpatient rehabilitation compared to inpatient rehabilitation or other models of community-based rehabilitation? • Can outpatient rehabilitation deliver comparable results at a lower cost compared to inpatient rehabilitation? If so, for what populations / conditions or under what circumstances? • Would enhancing outpatient rehabilitation drive efficiencies in the system by reducing demand elsewhere (e.g. reduced hospital re-admission rates, reduced hospital LOS, reduced costs)?
Analysis required	Compare inputs, outputs, and outcomes across similar types of outpatient rehabilitation programs.	Compare inputs, outputs, and outcomes for different types of rehabilitation programs across the continuum (e.g. outpatient and inpatient).
Considerations	Use fewer variables for initial development	This is more complex and time consuming but will be more informative to compare data across inpatient / outpatient datasets.

<u>Further discussion is required to:</u>

- Define patient diagnostic groups and programs
- Standardize indicators to measure inputs, outputs, and outcomes (e.g. to ensure comparable inputs of therapy frequency, intensity, LOS)
- Account for complexity and severity of patients (e.g. time post-injury/illness, presence of cognitive impairments)
- Account for differences in services provided (e.g. intensity, frequency, LOS)
- Account for differences in therapy goals (e.g. maintenance vs. rehab post acute-injury/illness)
- Consider opportunities to leverage existing data elements collected through NRS or NACRS

Confirm What Data/Information and What Outpatient Rehab Program / Service Types Will be Included

Options	Funding Source	Service Structure	Service Delivery Model
Details	Current funding for programs or patients include categories such as: • **Publicly Funded**: e.g., global hospital budget, Veterans Affairs. May or may not require a nominal fee • **Privately-funded**: WSIB, MVC, 3rd party extended health, out of pocket payment • **Combination** of the above	Current services are provided by: • **Hospital staff** providing services that are globally funded • **Hospital staff** providing for-profit services • **External Staff** providing services (which are hospital-governed) • **Combination** of the above, or other models	Current services are delivered based on models such as: • Single Service • Interprofessional • Medically focused with small rehab component Or • Assessment only • Assessment and Treatment • Self-management and Education only • Consultation-based
Proposed Direction	Include hospital-governed, publicly-funded programs; nominal fees are acceptable. Propose inclusion of OHIP-funded clinics.	Include services delivered by hospital-governed programs.	Include MOHLTC funded rehab services including single service and multidisciplinary programs. Allow model types to be differentiated in data. (see appendix)
Considerations	Considerations may be affected by directions of Quality Based Procedure funding models for outpatient/ambulatory rehab.	Query inclusion of for-profit clinics governed by hospitals. Consider how ambulatory, congregate clinics governed by the CCAC are to be included.	Suggest exclusion of assessment only clinics and those that are primarily medically focused.

Overview of Proposed Framework and Indicators for Performance Measurement of Outpatient Rehabilitation

Effectiveness

Patient Experience

What is the patient experience for those referred to outpatient rehab?

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- % of patients who would recommend the outpatient program to others
- % of patients who would not recommend the service
- % of patients that are satisfied with the service received
- % of patients who felt that they were involved in decision-making
- % of patients who decline the service

For those patients who are denied (see appendix for reasons), what other options are offered to patients and/or referrers to meet the patient's needs?

Consider use of standardized tool to measure patient satisfaction with outpatient rehab developed by Toronto Rehab and St. John's Rehab.

Consider use of caregiver burden scale to assess family perspective.

Clinical Outcomes

Are patients benefiting from outpatient services / programs? How much change is demonstrated?

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Consider reporting by:

- Rehab population – TBD
- Age group
- Amount of rehab received (see financial quadrant)
- Model of care (Group vs. 1:1; Patient directed modular sessions, etc.)

% of patients who achieve X% of the goals set at admission (e.g., based on GAS or RNLI)

% of patients who demonstrate improvement in pre/post assessment measures (e.g. general health, degree of informal support required, independence in functional skills, general communication ability, etc.)

Efficiency

Access & Transition

Did patients receive timely access? If not, why? Where did they transition from/to?

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What is the wait time?

- # of days: referral to 1st therapy session offered
- # of days: discharge from hospital to date of first therapy session
- How are patients prioritized? (see appendix)
- By discipline seen

Is client rehab ready at time of referral? If not, provide date of rehab readiness

Where patient is referred from:

- Acute care hospital
- Rehab hospital
- Primary care provider
- CCAC

Reason for Referral

Reasons for denial (see appendix).

Categorization of patient groups denied access (by primary diagnosis, rehab need, age, referral source, etc.)

Number of ED visits and/or hospital admissions within 30 days, 4 & 12 months post OPR & if new health issue?

Financial Performance

What are the costs of providing outpatient rehab programs / services? What are the relative costs compared to other programs / models, e.g., inpatient rehab?

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# of unique patients admitted or discharged in given period (quarterly)

Of these patients, how many 1:1 and group visits per discipline did they have? (MD/RN/OT/PT/SLP [assistants])

- Need to be able to report data from patient/provider perspective
- Cross reference with clinical outcomes quadrant

Report episode of care in days: Date of first therapy session to date of last therapy session (excluding. follow up visits)

Query measures of patient complexity/case mix?

Consider costs relative to other indicators, i.e., time to access, patient volumes served, outcomes achieved

Recommend standardization of these quadrants across rehab populations to the extent possible to enable comparison of information across programs. Depending on the specificity of clinical outcome data to be collected across programs, may need to consider population specific measures for this quadrant.

Appendix

Definitions

Visit: Reported for nursing visits only. The MOHLTC defines one visit as: "the number of times during which service recipient activities are provided face-to-face or by videoconference on an individual or group basis…for longer than five minutes." This may also include: "occasions when therapeutic intervention activities (e.g. education) are provided in lieu of a face-to-face visit…for longer than five minutes." A person may have more than one visit in a day.

Need to consider under what circumstances visits are required within the context of outpatient rehabilitation.

Attendance: Reported for allied health care only. The MOHLTC defines one attendance as: "a calendar day during which service recipient activities are provided face-to-face or by videoconference on an individual or group basis…and are provided for longer than five minutes." This may also include: "a calendar day during which therapeutic interventions activities (e.g. education) are provided by telephone in lieu of face-to-face attendance…for longer than five minutes." A person may have a maximum of one attendance per discipline per day.

Note: Issue with how activity is reported, i.e., whether 15 attendance days is for a physiotherapist seeing 15 patients throughout a given day or if 15 attendance days for the same therapist represents a 1 hour group session with 15 patients.[6]

[6] Alvarez, Rene, MOHLTC. Presentation October 18, 2012.

Declined Referrals

Proposed options for organizational recording of reasons for declined referrals.

	Top Reason	2nd reason	3rd reason	4th reason	5th reason
Psychiatric issues					
Continence issues					
Medical Condition/Complexity					
Behavioural issues					
Cognitive issues					
Infection Control issues					
Wandering issues					
Inability to access transportation					
Staffing/space shortage					
Program does not offer the requested service					
Wait list is too long to keep adding patients					
Access to third party funding					
Time since date of onset/injury is too long					
Program does not accept external referrals					
Resides outside of this program's/service's catchment area					
Other reason #1 (please specify)					
Other reason #2 (please specify)					
Other reason #3 (please specify)					

Prioritization

Proposed options for background information on how patients are prioritized on wait lists.

	Top Reason	2nd reason	3rd reason	4th reason	5th reason
Referral date (i.e. first come, first served)					
Date of injury/onset					
Access to third-party funding					
Receiving other community rehab services					
Medical Condition/Complexity					
Discharged inpatient from this organization					
Discharged inpatient from another organization					
Referred from an outpatient program within this organization					
Referred by a staff physician in this organization					
Referred from the community by a physician outside of this organization					
Catchment area of this program/service					
Other reason #1 (please specify)					
Other reason #2 (please specify)					

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