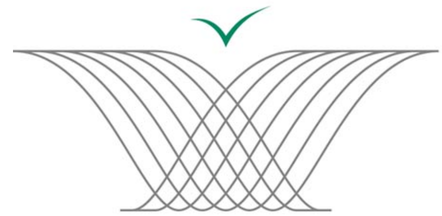
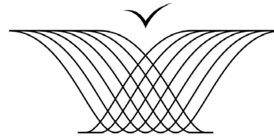


GTA REHAB
NETWORK

Leading by Design: Standardizing and Tracking the Information Used to Make Decisions on Access to Rehab Services

Referral and Response Form Task Group

May 2005



Leading by Design: Standardizing and Tracking the Information Used to Make Decisions on Access to Rehab Services

May 2005

Referral and Response Form Task Group

Greater Toronto Area Rehabilitation Network
550 University Avenue, Room 1114
Toronto, Ontario, M5G 2A2

Tel: (416) 597-3057 Fax: (416) 597-7021
info@gtarehabnetwork.ca www.gtarehabnetwork.ca

TABLE OF CONTENTS

Executive Summary …… **3**

Background …… **6**
Objectives …… 6
Motivation …… 6
Current Orthopaedic Landscape …… 8

Team Leadership …… **8**

Approach …… **9**
Selection of Musculoskeletal Rehabilitation as a Starting Point …… 10
Development of Guiding Principles …… 10
Development of Sample Reports …… 11
Development of Forms …… 11
Evaluation …… 12

Implementation of Pilot and Evaluation Process …… **12**
Critical Assessment of the HCMT Form …… 12
Initial Assessment of New Forms …… 13
Pilot Test …… 13

Pilot Outcomes and Discussion …… **14**
Implementation of Preadmission and Referral Forms …… 15
Implementation of the Response Form …… 15
Collection of System Wide Information …… 16
Generalizability and Expanded Use of the Forms …… 16
Challenges and Limitations …… 18

Recommendations …… **18**

Conclusions and Next Steps …… **21**

Task Group Membership and Acknowledgements …… **23**

Appendices …… **25**
Appendix I: Terms of Reference …… 25
Appendix II: Sample Reports …… 27
Appendix III: Evaluation Survey …… 31
Appendix IV: Pilot Background Material …… 35
Appendix V: Forms …… 39
Appendix VI: Pilot Test Results …… 47

GTA REHAB
NETWORK

EXECUTIVE SUMMARY

Objectives

The objectives of this initiative were to develop standardized referral, preadmission and response forms for musculoskeletal rehabilitation that would assist in improving access, accountability and transparency in the referral process from acute care to inpatient rehab at another facility. The forms could then be adapted for other populations and would provide the technological infrastructure for an electronic referral and wait list system that could be used for monitoring access, gaps and waiting lists in rehabilitation.

Motivation

The need for standardized referral forms was initially prompted by a report released by the GTA Rehab Network's Waiting List Task Group that recommended using common electronic referral and response forms as infrastructure through which information on the profiles and wait times of patients accepted, declined and wait listed for rehabilitation could be generated[1]. This information could then be used for assessing access, identifying gaps and advocating for unmet needs. In March 2003, a letter from the Central Emergency Network to the GTA Rehab Network also requested that the Network develop standard referral forms. In May of 2004, the GTA Rehab Network released one of the most comprehensive studies of ALC issues in the GTA. The need for standard referral forms was again highlighted throughout the report[2].

Current Orthopaedic Landscape

This initiative was originally motivated by issues related to inter-organizational communications, patient flow, waiting lists across rehabilitation, and a vision for a common referral form for all patient referrals. Musculoskeletal rehabilitation was selected as a starting point at the time, because few initiatives for this important population were in place. Since the inception of this initiative, however, the orthopaedic landscape has evolved considerably, with important changes planned in the area of total joint replacement care through the Toronto Joint Network (TJN). Through the TJN initiative, the need for assessing a simple orthopaedic patient's eligibility for rehabilitation will change. However, the need for communicating patient information will remain. The need to ensure that joint replacement care is also in line with the referral process for other musculoskeletal populations and other rehabilitation populations will also remain. It is therefore the intent of the GTA Rehab Network to work closely with the Toronto Joint Network to determine whether integration of these forms can contribute to the latter's strategy.

Approach

The approach used in this project involved a critical assessment of the previously used form, known as the HCMT form. Critical issues with the HCMT form related to time and ease of completion,

---

[1] GTA Rehab Network, *Measuring and Managing Supply and Demand: A Proposal for An Electronic Referral and Wait List System for Musculoskeletal Rehabilitation in the GTA*, 2003

[2] GTA Rehab Network, *Analysis of Alternative Level of Care (ALC) Snapshots: Patients Awaiting Rehabilitation in ALC and Inpatient Rehabilitation Capacity,* 2004

comprehensiveness, pertinence and formatting. Guiding principles were then developed for the new forms. Existing referral forms for stroke and acquired brain injury were also reviewed and the referral form of the Toronto Acquired Brain Injury Network was selected as a starting point. The pharmacy, physiotherapy and occupational therapy notes sections were discussed in small group settings. The preadmission form was abstracted from the full referral form. The response form was developed based on the set of responses that could possibly be given to a referral.

Evaluation

Evaluation of the forms consisted of an informal phase through which committee members brought the completed forms to their organizations to ask for feedback. Evaluation indicators included ease of completion, pertinence, completeness, objectivity, compliance with use of the form, and how often providers need to supplement referral form information with a phone call. The formal part of the evaluation involved a six-week phased-in evaluation in which the forms were used on actual patient referrals and evaluated on a weekly basis. The intent was to continue use of the forms after the evaluation with necessary revisions made to the forms. Eleven organizations participated in the pilot, which took place between November 1, 2004 and December 15, 2004. They included the six freestanding providers of rehabilitation, three acute care hospitals and two acute care community hospitals with both acute care and rehab beds on site.

Outcomes

The referral and preadmission forms were found to improve the communication between acute care and rehabilitation providers for the purpose of determining an acute care patient's eligibility for inpatient rehabilitation. They provided a mutually acceptable level of transparency, parsimony, completeness of information and objectivity for both the individuals who complete the referral and those who review them. The response form, however, was problematic because it was felt to be operationally unfeasible in its paper form. It may be more feasible however, if it were automated.

Recommendations

1: It is recommended that the revised MSK referral form be implemented for all complex patients who have undergone total joint replacement and for patients with hip fracture by May 2, 2005 for all Network member organizations making inter-organizational inpatient referrals. It is further recommended that discussion with the Total Joint Network occur regarding referral information.

2: It is recommended that the referral form be used for the other MSK diagnoses (upper and lower extremity fractures, pelvic fractures, and amputations) so that there is only one form on the acute care floor and that a task group be struck immediately to ensure that the elements on the form are amenable to its use.

3: It is recommended that the preadmission form be used for simple joint replacements and that its use be discussed for the Toronto Joint Network's initiatives.

4: It is recommended that formal required use of the response form for each patient referred be deferred until electronic capabilities are in place.

5: It is recommended that the response form be used only for patients declined until electronic capacity is put in place.

6: It is recommended that each organization maintain a list of patients declined using the headings on the response form and track the number of patients who fall under these response categories.

7: It is recommended that the GTA Rehab Network explore what is required to make referrals electronically, in order to ensure that there is implementation capacity at member organizations.

8: It is recommended that the GTA Rehab Network undertake a project to demonstrate the type of information we would derive from referral and response form information based on the sample reports developed through this initiative.

9: It is recommended that the GTA Rehab Network strike a task group to meet annually in order to evaluate use of the referral form and to modify areas that can be improved.

10: It is recommended that the GTA Rehab Network facilitate the development of the following elements: physiotherapy and occupational therapy notes; transfer information form.

11: It is recommended that the demographic, functional and social pages of the form be considered for a universal referral form and that further integration be made with the stroke referral form developed through the stroke pilot projects.

12: It is recommended that a stakeholder session be held with organizations doing internal referrals to determine the feasibility of using the form in-house.

13: It is recommended that the MSK form be expanded for ambulatory and outpatient referrals that are made directly from acute care.

Challenges and Limitations

Challenges inherent in the next steps for this initiative include: monitoring the data elements to ensure they are the correct ones for assessing patients' eligibility for rehabilitation; ensuring that implementation issues are resolved in a timely manner; ensuring that the forms do not weaken relationships established between organizations and providers to best meet the needs of the patient; ensuring that the forms stay relevant in a changing orthopaedic landscape; ensuring that the forms do not contribute to population specific silos; and investing in technology to enable the full potential of system planning information from electronic referrals.

Conclusions

New referral and preadmission forms have been developed through this initiative for the first time in nearly 30 years. For the first time, we also have a response form for patients declined. These forms improve the transparency, efficiency, and objectivity of assessing patients' eligibility for referral. The forms have been collaboratively developed and tested. Future automation could enable a rich source of system planning information, bringing us another step closer to a collective vision of a more coordinated rehabilitation system for the patients and families of the Greater Toronto Area.

BACKGROUND

A referral form is more than paper. It gives each patient a fair and equitable chance to be accurately and objectively described and assessed. This project is of significant impact to at least 3000 complex musculoskeletal patients[3] *who will be referred for inpatient hip fracture and possibly joint replacement rehabilitation over the coming year. If the forms are expanded for use with other rehabilitation populations, the number of patients that will be affected could increase significantly. When information from these forms is collated, we will have the capacity to advocate effectively for the needs of patients who cannot be served in our system or who experience lengthy waits. Finally, as per the valuation of the GTA Rehab Network on achieving a long-term vision of an electronic referral system while harnessing short-term benefits, the results of this project provide immediate operational returns for members by improving patient flow and inter-organizational communication.*

Objectives

The objectives of this initiative were to develop standardized referral and response forms for musculoskeletal rehabilitation that would assist in improving access, accountability and transparency through the referral process in order to support timely transitions across the continuum and free up acute care beds. The forms could then be adapted for other populations and would provide the basis for the technological infrastructure of an electronic referral and wait list system that would monitor access, gaps, and waiting lists for rehabilitation, without imposing additional data collection burdens on providers.

Motivation

The GTA Rehab Network membership includes the publicly funded organizations involved in the provision of rehabilitation services in the Greater Toronto Area. Its vision is an integrated rehabilitation system that is responsive to the needs of rehabilitation patients and their families and that achieves equitable and timely access to quality services at the right time and in the right place.

The Network seeks to achieve this vision by acting as a forum for collaboration and consensus building that enables its members[4] to coordinate services, promote equitable access, address gaps, reduce duplication, promote research and education, and measure performance of the rehabilitation system.

Improving access and ensuring system coordination are two of the GTA Rehab Network's core strategic directions. Making improvements in these areas is important not only because of access issues such as waiting lists but also because where access issues exist, we are not able to accurately characterize, quantify or even identify the root cause of the issue.

A number of studies conducted by the GTA Rehab Network demonstrated that the reasons for which a patient is wait listed or declined are not often tracked[5,6,7]. While some organizations may track refusals

[3] GTA Rehab Network, 2005 Analysis of National Rehabilitation Reporting System data on joint replacements and hip fractures.

[4] Members of the GTA Rehab Network include the 25 hospitals, 9 CCACs, the Ministry of Health and Long-Term Care, the University of Toronto, the Regional Geriatric Program, and the Toronto Acquired Brain Injury Network.

or wait lists, there was no common mechanism across the system. Information sources such as the National Rehabilitation Reporting System track outcomes for patients accepted into rehabilitation only. Not tracking patients declined or wait listed is problematic from accountability, transparency and advocacy perspectives. A report released by the GTA Rehab Network in 2003 demonstrated that there are five types of waiting lists[8] affecting access and that in order to improve access by reducing waiting lists, it is important to identify the correct reason for waiting.

To address this issue, a 2003 report released by the GTA Rehab Network's Waiting List Task Group recommended using common electronic referral and response forms as infrastructure through which information on the profiles and wait times of patients accepted, declined and wait listed for rehabilitation could be generated[9]. This information could then be used for assessing access, identifying gaps, and advocating for unmet needs. This was considered one of the few feasible ways of tracking access issues without imposing additional data collection burdens on providers. The system is described on pages 16-17 of this report.

In March 2003, a letter from the Central Emergency Network to the GTA Rehab Network also requested that the Network develop standard referral forms. In May 2004, the GTA Rehab Network released one of the most comprehensive studies of ALC issues in the GTA[10]. The need for standard referral forms was again highlighted throughout the report.

This current initiative provides a number of contributions to knowledge and innovation in the fields of inter-organizational communication, referrals, the assessment of musculoskeletal rehabilitation patients and the development of the infrastructure required to ensure accountability, transparency and objectivity as we assess a patient's eligibility for services and monitor access issues across the system.

Transparency and standardization in referral and response forms promote continuity of care for the patient, ethical practice, transparency and accountability. While the original intent was to focus on the referral and response forms, a preadmission form was also developed because the group felt the preadmission process for joint replacement patients was necessary to maintain patient flow until further system changes are made. It was the hope of the Referral and Response Form Task Group of the GTA Rehab Network that this initiative would provide a small but important step in the constant evolution of these commonly valued elements across our system.

---

[5] GTA Rehab Network, *Analysis of Alternative Level of Care Snapshots: Patients Awaiting Rehabilitation in ALC and Inpatient Rehabilitation Capacity*, 2004.
[6] GTA Rehab Network, *Measuring and Managing Supply and Demand: A Waiting List Information Management Proposal for Musculoskeletal Rehabilitation in the Greater Toronto Area,* 2003.
[7] GTA Rehab Network, *Clinical Committees Survey Report: Current Status of Rehabilitation in the Greater Toronto Area,* 2001.
[8] These include waiting lists caused by capacity, organizational policy, patient choice, placement, and complexity of patient need issues.
[9] GTA Rehab Network, *Measuring and Managing Supply and Demand: A Proposal for An Electronic Referral and Wait List System for Musculoskeletal Rehabilitation in the GTA*, 2003.
[10] GTA Rehab Network, *Analysis of Alternative Level of Care Snapshots: Patients Awaiting Rehabilitation in ALC and Inpatient Rehabilitation Capacity,* 2004.

Current Orthopaedic Landscape

This initiative was originally motivated by issues related to inter-organizational communications, patient flow, waiting lists across rehabilitation, and a vision for a common referral form for all patient referrals. Musculoskeletal rehabilitation was selected as a starting point at the time, because few initiatives for this important population were in place. Since the inception of this initiative, however, the orthopaedic landscape has evolved considerably, with remarkable changes and improvements planned in the area of total joint replacement care through the Toronto Joint Network (TJN). Through the TJN initiative, the need for assessing a simple orthopaedic patient's eligibility for rehabilitation will change. However, the need for communicating patient information will remain. The need to ensure that joint replacement care is also in line with the rehabilitation process for other musculoskeletal populations and other rehabilitation populations will also remain. It is therefore the intent of the GTA Rehab Network to work closely with the Toronto Joint Network to determine whether integration of these forms can contribute to the latter's strategy.

TEAM LEADERSHIP

The Referral and Response Form Task Group was struck upon approval of the GTA Rehab Network's 2004-2005 Operating Plan. Its membership consisted of one representative from each of the 9 organizations most involved in the inter-organizational transfer of patients from acute care to rehabilitation as well as two community hospital representatives. Both acute care and rehabilitation perspective were well represented.

Each of the participating organizations was approached through the GTA Rehab Network's Key Contact at the organization[11], to provide a representative from their organization who would serve on the committee. Organizations were asked to appoint individuals with the following characteristics:

- Familiarity with the referral process and the system issues involved in inter-organizational communication
- Ability to represent the views of the organization through consultation with relevant professionals
- Acumen needed to coach their organizational colleagues through the pilot, communicate objectives, solicit feedback, and encourage uptake.

In this manner, there was an organizational leader appointed to represent each of the organizations involved on the task group. This provided an external leadership structure. The terms of reference are included as Appendix I. The participating organizations included Toronto Rehab, West Park Healthcare Centre, St. John's Rehab Hospital, Providence Healthcare Centre, Mt. Sinai Hospital, St. Michael's Hospital, University Health Network, Scarborough Hospital and William Osler Health Centre. Baycrest also agreed to participate although was not able to send a representative to the task group.

[11] As a result of its participation agreements, the GTA Rehab Network has an organizationally appointed key contact at each of its member organizations that is responsible for providing the liaison between their organization and the GTA Rehab Network.

The formal internal leadership structure consisted of a triumvirate that included an externally appointed chair, a project manager and the Executive Director of the organization. This triumvirate worked together to ensure that a number of different types of leadership were provided to the committee: strategic leadership, human leadership, corporate leadership, process leadership and thought leadership.

The GTA Rehab Network provided the administrative support needed to set monthly meetings, between April 2004 and February 2005, distribute agendas, minutes, and discussion material, and also collate data from the evaluation initiative that formed part of this project. All committee members' contributions were in kind and the initiative had no other significant operational costs, making it a very efficient approach to making system change.

APPROACH

Consistent with the Plan-Do-Check-Act and Balanced Scorecard approaches that have become pervasive across quality movements, the Referral and Response Form Task Group began with a very clear sense of the objectives and intended outcomes which were stated as follows:

To develop and pilot a musculoskeletal referral, preadmission and response form that would:

- Enable a clear, accurate and objective description of the patient for the purpose of assessing eligibility.
- Increase transparency and ease of the referral process and support decision-making at receiving sites.
- Provide part of the infrastructure required to collect information on access without imposing additional data collection burdens on providers.

The process involved a series of steps that were selected with the view to ensuring an effective quality improvement process. The process involved a "Plan-Do-Check-Act" cycle, which included the following steps:

Table 2: Plan-Do-Check-Act cycle used for development, piloting and testing of the forms

Plan	▪ Conduct a critical appraisal of the HCMT form ▪ Critically assess the possibility of developing a generic form ▪ Develop principles to guide the form development
Do	▪ Develop referral, response and preadmission forms ▪ Develop a pilot evaluation protocol
Check	▪ Pre test the forms with member organizations ▪ Pilot implementation and result evaluation
Act	▪ Develop recommendations ▪ Plan and implement next steps (Plan Do Check Act)

The 'Plan' phase began with a critical appraisal of the form that was previously used (HCMT form). While stakeholders had already expressed interest in developing a form that was more conducive to

accurate, objective descriptions of the patient and to gathering access information, the group wanted to be respectful of previous work in the field and to build on what was known and tested. As such, a formal assessment of the HCMT form was conducted. In addition, a scan of other referral forms was conducted that included the forms used for stroke and for acquired brain injury. The form of the Toronto Acquired Brain Injury Network was used as a starting point.

Selection of Musculoskeletal Rehabilitation as a Starting Point

Given the strategic objective of having one overall referral form for all inpatient rehabilitation, consideration was then given to the scope of the initiative. It was felt that the form would ideally have generic components that could be expanded to any rehab population and would focus specifically on hip fractures and total joint replacements which make up over 70% of musculoskeletal rehabilitation cases. The rationale was as follows:

- **High Volume of MSK Patients:** The highest volume rehabilitation groups include hip and knee replacements, hip fractures, lower limb and pelvic fractures, stroke, spinal cord, acquired brain injury (ABI) and traumatic brain injury (TBI). Selecting hip and knee replacements and hip fractures will account for a large proportion of cases (70% of all musculoskeletal) without needing to consider too much diversity.

- **Existing Forms for Acquired Brain Injury and Stroke:** Through the Toronto Acquired Brain Injury Network and the regional Stroke Networks, these populations already have population specific forms.

- **Inter-organizational Impact:** It was felt that programs such as spinal cord and respiratory services are concentrated in too few organizations across the system and therefore focusing on these populations, as a starting point, would not have a sufficiently broad organizational impact.

- **Project Management and Feasibility:** It was felt that attempting to do too many populations would prove unfeasible from a logistical standpoint and that it would cause problems in examining the reliability and validity of the fields developed.

Development of Guiding Principles

The planning phase also involved the development of principles that would guide the overall form development. These principles were developed through a brainstorming session on what would constitute the ideal forms given the stated objectives. They were stated as follows:

- **Integrated and General Use:** The referral form will have core sections, which can be used for all rehabilitation population referrals, as well as population specific sections.

- **Population Based:** For the purposes of the Referral and Response Form Task Group, the forms will focus on hip and knee replacements and hip fractures.

- **Fairness:** The form should be constructed in a manner conducive to equitable and fair assessment of the patient's eligibility for services. Where the patient is not eligible, the description on the response form should point to why the patient was declined.
- **Transparent Disclosure:** To the extent possible, language on the forms should assist organizations in easily and accurately describing patients and should minimize subjectivity of interpretation.
- **Ease of Completion:** The referral form should be intuitive, obvious, and transparent in its requirements. It should not require tacit knowledge of processes or traditions and is easily used by a newcomer to the system.
- **Evolution of Data Quality:** Where uncertainty exists about the fields that should be used to describe patient attributes or conditions, open fields may be used with a view to evolving the descriptors at a later point.
- **Comprehensiveness, Parsimony and Pertinence:** The referral form should only contain the information required to accurately describe the patient and to appropriately assess the referral and determine eligibility for admission or preadmission.
- **Research and Evidence Based:** Where there is literature to indicate that certain indicators are effective assessment measures for rehabilitation, these indicators should be incorporated into the referral form.
- **Flexible Standardization:** Recognizing that the referral form cannot always fully describe patient situations, the form will be developed with the view to describing the majority of patients with the understanding that in a minority of exceptional cases, further dialogue will take place.
- **Respect for Diversity:** The form should be standardized for all organizations but should take into account the diverse needs of each organization.

Development of Sample Reports

The task group kept in mind that a secondary objective to the referral form was the collection of system wide information. As part of the planning process, the Referral and Response Form Task Group developed a number of potential system planning and access reports that could be used to ensure that both the referral and response forms contained the necessary data fields. These were used to ensure that the referral and response forms contained the appropriate data elements, not only for a patient referral and response, but also for ensuring that system and decision-making information is obtainable from the forms. Samples of the reports are provided in Appendix II.

Development of Forms

A number of group processes were used to cull the clinical insight of the committee members into an MSK specific form. Templates were designed and distributed prior to a number of meetings to enable committee members to gather their thoughts and feedback from their colleagues before the meetings.

For sections related to the transfer of information relating to occupational therapy, physiotherapy and pharmacy, a subgroup was struck to hammer out the details that would be required. These were brought

back to the group. The preadmission form, which is used to pre-book uncomplicated hip and knee replacement cases was developed by abstracting critical pieces of information from the referral form. Finally, the response form was developed based on previous work done by the GTA Rehab Network to determine what the different potential responses to a referral might be.

Evaluation

The evaluation of this project involved two phases. The first part was designed to solicit feedback from referrers and receivers on the elements and format of the forms. The benefit of this informal evaluation was not only to ensure that the elements are correct before having them used on actual patient referrals, but also that through the feedback, the individuals who would eventually use the forms would become familiar with them. The second part of the evaluation involved designing a pilot project and communication plan. The evaluation and pilot test are described in the next section.

IMPLEMENTATION OF PILOT AND EVALUATION PROCESS

Critical Assessment of the HCMT Form

In order to determine what exactly needed to be improved, the Referral and Response Form Task Group conducted a critical assessment of the originally used HCMT form. Task group members were asked to review the HCMT on the extent to which the form enabled ease and speed in completion, comprehensiveness and pertinence. The comments are summarized as follows:

- **Time and ease of completion:** Time and ease of completion of this form were enhanced by its familiarity. However, the formatting was problematic and it was often incomplete.
- **Comprehensiveness:** The major concern regarding comprehensiveness was that the fields were sometimes vague. They require tacit knowledge and were dependent on who completed them. The form also did not adequately describe complex patients.
- **Pertinence:** While reviewers felt that the form did not contain redundant information, the referrers felt that information could be condensed.
- **Best factors of referral form:** Providers felt that the form's familiarity was one of its best features and that the social and demographics pages were good.
- **Factors that should be modified for the new referral form:** The included formatting and clarity, space for writing as well as adding in more medical, occupational therapy and physiotherapy sections.
- **Changes that would need to be made to adapt the form for joint replacements:** These included shortening medical/functional piece; adding occupational therapy and physiotherapy sections; improving logical flow of information; clarifying use of form.
- **Changes that would need to be made to adapt the form for hip fractures:** These include clarifying weight bearing definitions and language; indicating the type of surgery, if any; and providing co-morbidity, medical history; and pain management sections.

Initial Assessment of New Forms

To monitor the extent to which the new forms addressed the issues noted above as well as the principles determined by the task group, a two-phased test was conducted. After completion of the forms, the task group members took them back to their organizations. The forms were evaluated informally using the same criteria as used in the critical appraisal of the HCMT form. Given the comfort level of the users with the forms during the first part of the 'check' and the clear identification of the problem at the onset, the task group agreed that the pilot would be designed as a phased-in evaluation. In other words, there was no intent once the pilot began, to revert to the old forms.

Pilot Test

Once the group was reasonably confident that the forms would not cause problems in patient flow, a six-week phase-in and evaluation were conducted. The objective was to test the new forms on actual patient referrals in a controlled manner to ensure that they did not cause any delay in the referral process. Each organization was asked to evaluate the forms on a weekly basis in order to control for the effects of familiarity.

The overall questions that we wanted to answer from the pilot test included:

- Are we facilitating an accurate and appropriate description of the patient for referrers?
- Are we facilitating a simplified review and assessment of the patient for assessors?
- Are we minimizing subjective text entries used to describe or assess the patient?
- Are there elements missing from the form? Are there elements that are redundant?

The pilot was designed to test the forms and would provide the feedback and information needed to optimize their performance and the comfort of the users. Table 3 describes the evaluation indicators selected for the pilot based on a *Balanced Scorecard* approach, the stated objectives, and the principles developed.

Table 3: Evaluation indicators selected for the checking phase

Quadrant	Indicator	Explanation
Clinical	▪ Succinct	▪ To what extent do the forms enable the most succinct description of the patient?
	▪ Pertinent	▪ To what extent do the forms ask for the right elements needed to make a referral or response decision?
	▪ Comprehensive	▪ To what extent does the form contain all the elements needed to assess the referral form?
	▪ Objective	▪ To what extent does the referral form facilitate transparent disclosure and an objective assessment and description of the patient?
Operational	▪ Ease of completion	▪ To what extent are the forms easy to complete?
	▪ Need for phone call	▪ To what extent does the information on the forms need to be supplemented by/clarified with a phone call?

Quadrant	Indicator	Explanation
Satisfaction	▪ Uptake/use of forms	▪ How many referrals were received on the new forms compared to the total number of referrals received?
	▪ Reasons for non compliance	▪ Where the telephone was used to supplement information on the form or instead of the form, why did this occur?
Financial[12]	▪ Time required to complete the application	▪ How much time was required to complete the referral, preadmission and response forms?

For each indicator, a five-point Likert scale was provided. Where the reviewer gave a score of less than four out of five, the evaluation form asked the respondent to identify what the issue was that prevented the form from scoring a four or five out of five on that particular dimension. This strategy was used to ensure that all responses were action oriented, since there was no intent to revert to the previous forms. A sample evaluation form is provided in Appendix III.

The pilot project lasted six weeks beginning November 1, 2005 and running to December 15, 2004, inclusive. Following the first two weeks, each of the acute care hospitals continued to use the new referral form. At the end of each pilot week, they assessed the amount of time taken to complete the referral form and the extent to which they felt the forms contained the necessary or redundant information on the patient. A short questionnaire was to be completed at the end of each week, on that week's referrals. At the providers' end, the providers received referrals on the new referral forms and evaluated the extent to which the referral was complete and the extent to which there was redundant information. They were also asked to complete a response form for each referral and to complete the evaluation questionnaires on a weekly basis.

Process changes were made largely through the use of structured communications. Members of the Referral and Response Form Task Group were provided with the following materials, which are presented in Appendix IV, to enable implementation of the new forms at their organizations.

- Instructions for the pilot and the committee members' role as team leader
- A background document that could be used to disseminate information on the pilot
- A set of instructions for use of the form
- Evaluation surveys for each of the preadmission, referral and response forms

PILOT OUTCOMES AND DISCUSSION

Implementation of Preadmission and Referral Forms

The triad of forms, presented in Appendix V, which have been developed through this initiative, improved the communication between acute care and rehabilitation providers for the purpose of determining an acute care patients' eligibility for rehabilitation. They provided a mutually acceptable

[12] Since referral and response formed part of the previous practice, changing the form (if it did not introduce additional time requirements) would not have a direct financial impact. Potential indirect impacts may accrue in terms of efficiency and cost savings if patients are more appropriately referred and if the forms eliminated the need for phone calls back and forth to rectify client status issues, however, this was not measured.

level of transparency, parsimony, completeness of information and objectivity for both the individuals who complete the referral and those who review them. This was demonstrated through the pilot study, which showed favourable responses from both acute care referrers and rehabilitation providers. Results of the pilot project are presented in Appendix VI.

The revised MSK referral or preadmission forms are now being used for all hip fracture and hip and knee replacement patients. The referral form received positive feedback from the participants in the pilot project. Although the preadmission process does not promote the notion of assessing the patients' true need for inpatient rehabilitation, it is an operational boon because it keeps patients flowing through the system. At this point, the task group feels it is necessary to maintain the preadmission process.

The use of these forms was also considered in light of the current initiatives relating to total joint replacement that have recently been put in place through the Toronto Joint Network. Through the TJN initiative, the need for assessing a patients' eligibility for rehabilitation will change. However, the need for communicating patient information will remain. The need to ensure that joint replacement care is also in line with rehabilitation for other musculoskeletal populations and other rehabilitation populations will also remain. It is therefore the intent of the GTA Rehab Network to work closely with the Toronto Joint Network to determine whether integration of these forms can contribute to the latter's strategy.

Implementation of the Response Form

Implementing the response form proved to be more complex. Completing a response form for each patient referred is very labour intensive because the current practice in the GTA is to make multiple referrals for each patient. If it were an electronic referral, completing a response form for each new patient could be facilitated, but given the manual completion requirement and the need for a phone call anyway, the practice was not considered efficient at this time. It was recommended that formal required use of the response form for each referred patient be deferred until electronic capabilities are in place.

However, given the valuation on accountability and on developing the capacity to advocate for unmet needs, a recommendation was made to use the response form only for patients declined. The telephone would continue to be used for patients accepted and wait listed. This is a compromise position between imposing data collection for a large number of patients and ensuring that there is data available for advocacy and transparency purposes. The response form would be completed only for patients declined.

It was therefore recommended that, until such time that an electronic response is made possible, each organization should maintain a list of patients declined using the headings on the response form. This provides an improvement to the *status quo* by ensuring that the information on patients declined is available in a standard and common manner across the system.

Collection of System Wide Information

While the referral, response, and preadmission forms achieved their goals of improving the quality of referral information and inter-organizational communications, they also further the strategic objectives of access and coordination embraced by the GTA Rehab Network. When the data from the referral and response forms is collated, information on the profiles and wait times of patients accepted, declined and wait listed for rehabilitation can be generated. This information could then be used for assessing access, identifying gaps, and advocating for unmet needs. The system is described in Figure 1.

General and Expanded Use of the Forms

The Referral and Response Form Task Group also considered how to ensure that the form could be transferable to other rehabilitation populations. This was considered operationally important because over time, a universal referral form for rehabilitation would facilitate the process and the collection of system planning information. With a common referral form for all populations, there will be capacity to cross-prioritize across populations. There were three types of generalizability and transferability that were considered and for which specific recommendations are provided in the recommendations section.

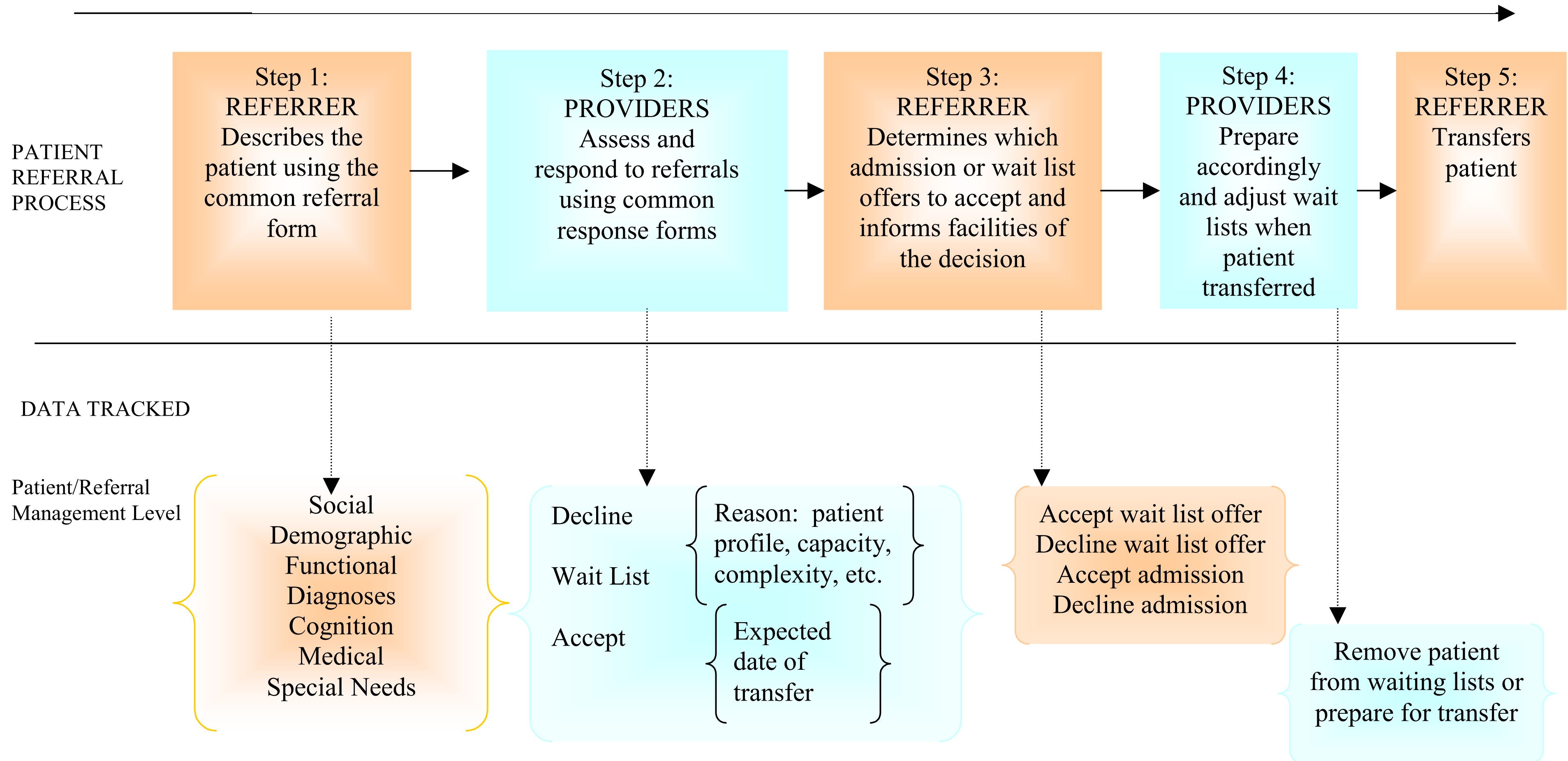
Firstly, it was recommended that the social, demographic, and functional sections of the referral form be considered for a universal referral form. Committee members requested that the use of the form be expanded to include pelvic fractures, amputations, and upper and lower extremity fractures so that there would only be one referral form on the acute care floor. It is the hope that this MSK referral form, the current Acquired Brain Injury form, and the current Stroke form can be further integrated over time. This will standardize referrals for at least 70% of inpatient rehabilitation and would facilitate referrals in general and system planning in particular.

Secondly, it was also recommended that the MSK form be expanded for ambulatory and outpatient referrals that are made directly from acute care. Throughout rehabilitation, it is recognized that the focus is most often on inpatient services and that greater use of outpatient and ambulatory care maybe desirable in the future. By expanding the referral form to include outpatient referrals, there may be greater sensitivity and awareness raised to a patient's eligibility for and benefit from outpatient rehabilitation which may translate to re-listing outpatient care in the bundle of funded services.

Finally, the transfer of these forms was considered from the current inter-organizational use to intra-organizational use. Since a number of organizations transfer patients from acute care to rehabilitation within their own institutions, less patient-related information is required. While a strong case can be made for the use of appropriate referral information across organizations, organizations with their own in-house rehabilitation beds do not use a referral form currently. This causes equity and transparency issues. Opening the dialogue in this area could lead to a more transparent and accessible system.

Figure 1: Linkage between referral, response and preadmission forms and system planning

Every step is date stamped to record waiting times. Information on each step linked for each patient.



ANALYTICAL REPORTS

System/ organization level

Waiting time:

- How long does it take to refer patients?
- How long does it take to admit?

Patient profiles:

- What types of patients are being referred?

Access by patient type:

- What types of patients are accepted, declined, wait listed?
- What types of services do we need more of?

Reason for lack of access:

- Why are patients wait listed or declined i.e., capacity, special needs etc.?

Referral management:

- Is this patient on multiple waiting lists?

Challenges and Limitations

While this project has achieved its goals, it presents a number of challenges that will need to be considered and addressed as we move forward:

- **Data quality and evolution:** Further exploration of the data elements on the form will need to occur to ensure that the most relevant and parsimonious data elements are being used to assess a patient's eligibility for rehabilitation, since literature in the area is sparse.
- **Implementation:** As the form is implemented, there may be practical and operational issues that need to be addressed. The GTA Rehab Network will need to strike a task group to monitor implementation and use of the forms.
- **Maintaining effective relationships:** Studies have shown that forms and information systems can sometime limit discussion and problem solving between professionals. Ensuring that the process is not depersonalized will be important in supporting the success of standard referral forms.
- **Ensuring a focus on patient advocacy:** While referral forms describe a majority of patient cases, there will be a minority of patients whose situations cannot be accurately or adequately described by the form. While the forms are intended to facilitate the process, they should not preclude consideration of unique patients or their circumstances.
- **Maintaining relevancy in a changing orthopaedic landscape:** With the rapid pace of change in policy and practice for joint replacement patients, an active effort will need to be made to ensure that the forms maintain their relevancy and integration in evolving practices.
- **Avoiding the potential for population specific silos:** This initiative has led us to a standardized form for musculoskeletal rehabilitation. There are also standard forms for stroke and acquired brain injury in place. It will be important to ensure that these large population groups can merge common data elements to facilitate system planning and efficiency.
- **Investing in technology:** The true potential of deriving system planning and access information on an ongoing basis from referral and response forms, without imposing data collection burdens on providers, requires an investment in technology.

RECOMMENDATIONS

A. USE OF FORMS

1. Use of Referral Form and Preadmission Form

Recommendation 1: It is recommended that the revised musculoskeletal (MSK) referral form be implemented for all complex patients who have undergone total joint replacement and for patients with hip fractures by May 2, 2005 for all Network member organizations making inter-organizational inpatient referrals. It is recommended that further discussion with the Total Joint Network occur regarding referral information.

The referral form received positive feedback from the pilot project. As patients become more complex, it will be increasingly important from both a funding and an access perspective to describe MSK patients

in sufficient detail to assess their eligibility or to collect specific information on why the patient is not able to get access. Such descriptions will also enable better funding decisions in the future.

Recommendation 2: It is recommended that the new MSK referral form, although tested only for joint replacements and hip fractures, be used for upper and lower extremity fractures, pelvic fractures and amputations.

While the referral form was tested for joint replacements and hip fractures which account for the largest proportion of musculoskeletal patients, it was felt that having two forms on the musculoskeletal floor would cause inefficiencies. The group felt that the form would work for the other single fractures and amputations, especially if the open fields were used to fill in missing information. In order not to damage the integrity of the testing process, the form would have a note stating that the referral form has been tested for joint replacements and hip fractures but not for the other diagnoses. A task group would be struck immediately to flesh out the needed data elements.

Recommendation 3: It is recommended that the preadmission form be used for simple joint replacements.

Although the preadmission process does not promote the notion of assessing the patients' true need for inpatient rehabilitation, it is an operational boon because it keeps patients flowing through the system. At this point, the task group feels it is necessary to maintain the preadmission process. Further discussion will occur with the Total Joint Network regarding how the preadmission form may integrate in Total Joint Network initiatives.

B. USE OF RESPONSE FORM

Recommendation 4: It is recommended that formal required use of the response form for each patient referred be deferred until electronic capabilities are in place.

Completing a response form for each patient referred is very labour intensive because for each patient there will be multiple referrals. If it were an electronic referral, such response could be facilitated, but given the manual completion requirement and the need for a phone call anyway, such a practice is not considered efficient at this time.

Recommendation 5: Until such time that an electronic response is made possible, it is recommended that the response form be used only for patients declined.

This is a compromise position between imposing additional form completion for a large number of patients and ensuring that there is data available for advocacy and transparency purposes.

Recommendation 6: Until such time that an electronic response is made possible, it is recommended that each organization maintain a list of patients declined using the headings on the response form and track the number of patients who fall under these response categories.

This provides an improvement to the status quo by ensuring that the information on patients declined is available in a standard and common manner across the system.

C. USE OF TECHNOLOGY FOR REFERRALS AND SYSTEM PLANNING

Recommendation 7: It is recommended that the GTA Rehab Network explore what is required for electronic referrals in order to ensure that there is implementation capacity at member organizations, i.e., availability of computers, consent issues, ability issues, etc.

Currently referrals are filled out manually and by multiple provider types. Exploring the possibility of an electronic referral would enable us to know where the gaps are if we are to move to electronic referral.

Recommendation 8: It is recommended that the GTA Rehab Network undertake a project to demonstrate the type of information we would derive from the referral and response forms. The pilot would be based on the manual collection of information and the participation of two or three organizations.

As part of the Referral and Response Form Task Group's initiative, a number of potential reports were generated that were used to ensure that both the referral and response forms contained the necessary information. Using those reports as a starting point, an assessment would be made of the information.

D. CONTINUOUS IMPROVEMENT AND EVALUATION

Recommendation 9: It is recommended that the GTA Rehab Network strike a task group to meet annually to evaluate use of the referral form and to modify areas that can be improved.

One of the principles for the use of the referral and response forms was constant data evolution and improvement. Monitoring the use and data elements within the evaluation form could lead to constant improvement and the recognition of any system issues.

Recommendation 10: It is recommended that the GTA Rehab Network facilitate the development of the following elements:

a. Physiotherapy and occupational therapy notes
b. Transfer information form

While development of the referral form helped clarify our understanding of what elements of the physiotherapy and occupational therapy notes are needed for a referral, there is still potential to hone this in further. Similarly, the referral form was designed for assessment. A transfer information form could help to ensure that the appropriate information is complete and available once the patient is referred for rehabilitation.

E. GENERAL REFERRAL FORM

Recommendation 11: It is recommended that the demographic, functional and social pages of the form be considered for a universal referral form and that further liaison be made with the stroke referral form developed through the stroke pilot projects.

A common referral form for all of rehab could facilitate referrals in general and system planning in particular. While MSK accounts for the largest proportion of inpatient rehabilitation cases, stroke is the second largest group. Therefore, consolidating these two groups would streamline the referral process greatly.

F. USE OF THE FORMS FOR IN-HOUSE REFERRALS

Recommendation 12: It is recommended that a stakeholder session be held with organizations doing internal referrals to the feasibility of using the form in house.

While a strong case can be made for the use of appropriate referral information across organizations, organizations with their own in-house rehabilitation beds do not use a referral form currently. This causes equity and transparency issues. Opening the dialogue in this area could lead to a more transparent and accessible system.

G. OUTPATIENT AND AMBULATORY CARE REFERRALS

Recommendation 13: It is recommended that the MSK form be expanded for ambulatory and outpatient referrals that are made directly from acute care.

Throughout rehabilitation, it is recognized that the focus is most often on inpatient services and that greater use of outpatient and ambulatory care may be desirable in the future. By expanding the referral form to include outpatient referrals, there may be greater sensitivity and awareness raised to patients' eligibility for and benefit from outpatient rehabilitation, which may translate to the re-listing of outpatient care in the bundle of funded services.

CONCLUSIONS AND NEXT STEPS

Leading by Design: Standardizing and Tracking the Information Used to Make Decisions on Access to Rehab has resulted in the development of a triad of forms that facilitates client movement between acute care and rehabilitation hospitals for musculoskeletal (MSK) patients.

The initiative has a measurable and direct impact on patient flow and access. It also promotes fair and equitable assessment of a patient's eligibility for inpatient rehab in a manner that is transparent and accountable to patients and providers alike. It has embraced a methodological approach, incorporated evaluation and implementation considerations, and relied on the collaborative effort, expertise and skill of the individuals involved.

As a result, we have musculoskeletal referral, preadmission and response forms that are conducive to an objective assessment of the patient's eligibility for rehabilitation and the beginning of the infrastructure

needed to responsibly monitor and report on access issues. These forms have the potential to be converted into an electronic format conducive to future automation.

The values expressed and honoured through this initiative include transparent disclosure, integration, parsimony, completeness, fairness, evidence-based, evaluation and respect for diversity in the evaluation of a patient's eligibility for service. To ensure that these values were translated, the task group's approach involved multiple consultations and meetings and a pilot study, which was conducted across each of the 11 organizations in November 2004. Next steps should include a prioritization and implementation of the recommendations provided earlier in this report.

We expect that by the end of one year at least 3000 inpatient rehabilitation referrals will be made using the forms and that the forms will provide standardized information that lends itself to improving accountability and the ability to advocate for unmet patient needs. Improving access, patient flow, transparency and accountability through initiatives such as ***Leading by Design*****,** brings us yet another step closer to the GTA Rehab Network's vision of a more coordinated rehabilitation system for the patients, families and providers of the Greater Toronto Area.

TASK GROUP MEMBERSHIP

Wendy Abbas/Connie Stamp, *Patient Care Manager, Orthopaedics and Amputee Rehab, Providence Healthcare*

Cathy Brandt, *Manager, Program Services, Toronto Rehab*

Catherine Cotton, *Patient Care Director, Orthopaedics and Rehab, The Scarborough Hospital*

Tanya Jonkman and Maria Martinez *(on leave)*, *Social Workers, University Health Network*

Mary-Grace Grossi, *Professional Practice Leader, St. John's Rehab Hospital*

Debbie Galet, *Discharge Planner/Clinical Educator, St. Michael's Hospital*

Vilma Rusac, *Care Coordinator, Geriatric & MSK Rehab, West Park Healthcare Centre*

Kim Sterling, *Case Manager, MSK Program, Bridgepoint Health*

Gilda Theriault, *Resource Nurse, William Osler Health Centre*

Suesan Way, *Social Worker, MSK Representative, Mt. Sinai Hospital*

Heather Brien, *Client Service Manager, ABI Program, Toronto CCAC (Chair)*
(Acting Executive Director of GTA Rehab Network since March 1, 2005)

Charissa Levy, *Executive Director, GTA Rehab Network (on leave)*

Tina Saryeddine, *Project Manager/Senior Planner, GTA Rehab Network*

ACKNOWLEDGEMENTS

The Referral and Response Form Task Group would like to thank the following individuals for their contributions to this project: Ms. Laurie Hurley, currently of the Arthritis Society and formerly of the SCRIPT project and Ms. Nicola Tahair of the SCRIPT Project for sharing the SCRIPT experience in referral form development; Ms. Judy Moir of the Toronto Acquired Brain Injury Network for providing insight into the ABI experience; Mr. Robert Jessop for his work on the layout and formatting of the forms; Ms. Suzanne Line for her assistance in entering pilot data; and Ms. Patty Aird, for organizing our meetings, venues and scheduling.

Finally, the GTA Rehab Network would like to acknowledge and thank all of the individuals who provided feedback both through the pilot studies and the informal requests for feedback. Your perspectives and dedication bring us closer to a vision of a more integrated rehabilitation system.

GTA REHAB
NETWORK

APPENDIX I

TERMS OF REFERENCE:
REFERRAL AND RESPONSE FORM TASK GROUP

Background

In the document, *Measuring and Managing Supply and Demand: A Waiting List Information Management Proposal for Musculoskeletal Rehabilitation in the Greater Toronto Area*, a recommendation was made to develop common referral and response forms for musculoskeletal rehabilitation. In the short term, these forms could help to streamline the referral process by ensuring that sufficient and appropriate information is provided upon referral and upon response to a referral. In the longer term, common referral and response forms can be automated and data from the forms can be used to measure and manage waiting lists.

Mandate

To develop, pilot and implement common referral and response forms for hip fracture and joint replacement patients.

Accountability

The committee is accountable to the Coordinating Council of the GTA Rehab Network and to each of the member organizations.

Membership

Membership on committees should reflect the whole Network, with Committee members having the skills and experience appropriate to the task of the committee/group.

Current membership on the committee includes:

Wendy Abbas	Patient Care Manager, Ortho, Amp Rehab	Providence Healthcare
Heather Brien	Client Service Manager, ABI Program (Chair)	Toronto CCAC
Cathy Brandt	Manager, Program Services	Toronto Rehab
Catherine Cotton	Patient Care Director, Orthopaedics and Rehab	The Scarborough Hospital
Lindsey Crawford	Director, Allied Health Professional Practice	University Health Network
Mary Grace Grossi	Professional Practice Leader	St. John's Rehab Hospital
Debbie Galet	Discharge Planner/Clinical Educator	St. Michael's Hospital
Charissa Levy	Executive Director	GTA Rehab Network
Vilma Rusac	Care Coordinator, Geriatric & MSK Rehab	West Park Healthcare Centre
Tina Saryeddine	Project Coordinator/Planner	GTA Rehab Network
Kim Sterling	Case Manager, MSK Program	Bridgepoint Health
Gilda Theriault	Resource Nurse	William Osler Health Centre
Suesan Way	Social Worker, MSK Representative	Mt. Sinai Hospital

Length of Term

Membership on the task force is for a period of six months or until the activities are completed to the satisfaction of the task group.

Chair of the Committee

Heather Brien

Frequency of Meetings

To be determined

APPENDIX I
TERMS OF REFERENCE:
REFERRAL AND RESPONSE FORM TASK GROUP

Budget and Resources
Resource needs for the Committee will be forwarded to the Coordinating Council though the Network office for consideration in the budget. Where deemed necessary or desirable by the committee, consultations by experts outside of the Network may be invited.

Functions
- Develop, pilot and implement a standard referral form for MSK including a preadmit form for joint replacement cases
- Develop, pilot and implement a standard referral response form for MSK
- Develop, pilot and implement common referral and response protocols for MSK
- Clarify the use and expectations around the forms and protocols, e.g. use for admission information, use for preadmission, use for assessment, etc.

Critical Path

Activity	*Month*
1. Initial decisions on scope and approach to referral and response form development	April 7
2. Determine principles for the construction of the ideal referral and response form	May 6
3. Review draft form and initial feedback from GTA Rehab Network members	May 6
4. Revise draft form based on principles of the ideal form and feedback from members	May 6-June3
5. Develop referral response form and processes for sending and responding to referral	July 8
6. Outline protocol for the pilot	July 8
7. Conduct pilot	August 1-Sept.-30
8. Revise forms based on pilot and stabilize use of forms	October

Deliverables
- Standard referral and response forms including a preadmit form for joint replacements
- Standard expectations around referrals and response protocols between organizations

Expected Impact
- Increased ease and speed of referral and response
- Improvements in patient flow and reduced communication burdens
- Clear standards and transparency in the referral process
- Potential ability to profile patients accessing, waiting, or being declined for service
- Clarity on what the information on the forms is used for

APPENDIX II

SAMPLE REPORTS

DYNAMIC REAL TIME REPORTS

Patients currently In beds

number of designated funded rehabilitation beds	this is an opening number that remains the same
number of males	
number of females	
number of private room patients	
number of semi private room patients	
number of patients admitted within the past 7 days	(this is an opening number that remains same)
number with comorbidities	from the database
number with special needs	
number with cognitive issues	
number who wonder	
number of diagnoses 1	
Patients accepted and on waiting lists	
number of designated funded rehabilitation beds	
number of patients admitted within the past 7 days	
number with comorbidities	average time to admission
number with special needs	average time to admission
number with cognitive issues	average time to admission
number who wonder	average time to admission
Average wait time/patient	
Median wait time	

This type of report would be accessible to all referrers and responders by organization. It would serve as a real time report intended to give referrers a sense of what the wait times are like for different types of patients at different types of organizations. It is important to note that this report would not be calculated based on the current referrals and responses in order to calculate average wait times. It would not be an automatic guarantee of wait times, but a mechanism for referrers to determine in advance, where they may have the best chance of having a patient admitted swiftly.

APPENDIX II

SAMPLE REPORTS

Provider Summary Sheet	
Number of referrals received	
Facts about patients accepted for rehabilitation	
Number Accepted	Number and percentage of total with comorbidities
	Number and percentage of total with cognitive issues
	Number and percentage of total with special needs
	Number and percentage of total with behavioural issues
	Number and percentage of total who wonder
	Number and percentage of total with 2-5 of the above
Waiting Time	Days between referral received and facility acceptance
	Days between facility acceptance and transfer of patient
	Number and percentage of acceptances not taken by the referrer
	Organizations from which referrals accepted
Characteristics of patients declined	
	Number and percentage of total with comorbidities
	Number and percentage of total with cognitive issues
	Number and percentage of total with special needs
	Number and percentage of total with behavioural issues
	Number and percentage of total who wonder
	Number and percentage of total with 2-5 of the above
Referral Response Reason for Patient Declined	
	Patient's Medical Needs are too complex for program
	Waiting lists are to a point where no additional patients are accepted
	Cognitive issues of the patient can not be addressed at this facility
	Cognitive issues of the patient can not be addressed at this time
	Special needs required by patients can not be met at this facility
	Special needs required by patients can not be met at this time
Waiting Time	Days between referral received and facility acceptance
	Days between facility acceptance and transfer of patient
	Number and percentage of acceptances not taken by the referrer
	Organizations from which referrals accepted
Referral Response Wait Listed Patients	
	Number and percentage of total with comorbidities
	Number and percentage of total with cognitive issues
	Number and percentage of total with special needs
	Number and percentage of total with behavioural issues
	Number and percentage of total who wonder
	Number and percentage of total with 2-5 of the above
	Days between referral sent and response
	Days between referral response and admission
	Days between referral response and ALC designation if any
	Days between referral and admission
Number Wait Listed	Patient's Medical Needs are too complex for program
	No patients are currently being placed on the waitinglist
	Insufficient capacity and staffing to meet patients' need
	Mix of patients on the floor does not allow acceptance of patient
	Special needs required by patients can not be met at this facility
	Special needs required by patients can not be met at this time
Waiting Time	Days between referral sent and response
	Days between referral response and admission
	Days between referral response and ALC designation if any
	Days between referral and admission

APPENDIX II

SAMPLE REPORTS

System Wide Monthly Reports- Referrers		Days between referral sent and response	Days between referral response and admission	Days between referral response and ALC designation if any
Patient Accepted	Number and percentage of total with comorbidities			
Characteristics	Number and percentage of total with cognitive issues			
	Number and percentage of total with special needs			
	Number and percentage of total with behavioural issues			
	Number and percentage of total who wonder			
	Number and percentage of total with 2-5 of the above			
Patients Declined				
Characteristics	Number and percentage of total with comorbidities			
	Number and percentage of total with cognitive issues			
	Number and percentage of total with special needs			
	Number and percentage of total with behavioural issues			
	Number and percentage of total who wonder			
	Number and percentage of total with 2-5 of the above			
Patients Declined				
Referral Response	Patient's Medical Needs are too complex for program			
	No patients are currently being placed on the waitinglist			
	Insufficient capacity and staffing to meet patients' need			
	Mix of patients on the floor does not allow acceptance of patient			
	Special needs required by patients can not be met at this facility			
	Special needs required by patients can not be met at this time			
Referral Response Wait Listed Patients				
	Number and percentage of total with comorbidities			
	Number and percentage of total with cognitive issues			
	Number and percentage of total with special needs			
	Number and percentage of total with behavioural issues			
	Number and percentage of total who wonder			
	Number and percentage of total with 2-5 of the above			
Number Wait Listed	Patient's medical needs are too complex for program			
	No patients are currently being placed on the waitinglist			
	Insufficient capacity and staffing to meet patients' need			
	Mix of patients on the floor does not allow acceptance of patient			
	Special needs required by patients can not be met at this facility			
	Special needs required by patients can not be met at this time			

APPENDIX II

SAMPLE REPORTS

Organization specific report					
	Patient 1	2	3	4	…
Accepted by					
Declined by					
Wait listed by					
Admitted by					
Comorbidities					
Cognitive issues					
Special needs					
Diagnoses					
Referral to response					
Response to transfer					

This report would be generated monthly through the database for each referring organization. It is a list of patients referred, the response to the referral, and characteristics of the referral. This type of report could be used by referring organizations for planning purposes, for identifying where potential relationships can be strengthened and for program development purposes.

APPENDIX III

EVALUATION SURVEY

REFERRAL, RESPONSE, AND PREADMISSION FORMS

FAX BACK COVER SHEET:

Attention: Tina Saryeddine
GTA Rehab Network

FAX #: 416-597-7021

From: ____
____
____

Date: ____

==

INSTRUCTIONS

Thank you for completing this survey questionnaire to help evaluate the rehab referral, preadmission and response forms for musculoskeletal patients.

This package contains three evaluation forms that need to be completed in order to evaluate each of the preadmission, referral and response forms.

You should complete each of the evaluation surveys on the following dates and fax to Tina Saryeddine, Project Manager/Senior Planner at 416-597-7021

November 19, 2004
November 26, 2004
December 3, 2004
December 10, 2004

On December 15, providers will be asked to compare 10 randomly selected actual patients to their referral form description. A form will follow for this purpose at a later date.

If you have any questions, please don't hesitate to contact Tina Saryeddine at 416-597-3422 x 3924 at any time.

PREADMISSION FORM EVALUATION SURVEY

1. Please provide your name, email, organization, and position:
Name:____________________________________ Organization:______________________________
Email:____________________________________ Position:____________________________________

2. Are you a referrer _________ or referral recipient _________?

3. How many preadmission forms did you complete/receive in total this week? __________

4. How many minutes on average did it take to complete each?________________minutes

5. How many preadmissions did you complete on other preadmission forms _____________
Why?____

6. Ease of Completion: Rate the ease of completion/review of this form: **(Low) 1 2 3 4 5 (High)**
If you rated the form as a 1,2, or 3 please describe where the difficulties lie: _____________________
____
____

7. Succinctness: To what extent do you feel information fields are succinct? **(Low) 1 2 3 4 5 (High)**
If you answered 1, 2 or 3, please describe what is redundant_________________________________
____
____

8. Pertinence: Does the form request the information that is important? **(Low) 1 2 3 4 5 (High)**
If you answered 1, 2, or 3 please describe what elements need to be added or removed _____________
____
____

9. Objectivity: To what extent do you feel this form enables an objective description of the patient?
(Low) 1 2 3 4 5 (High)
If you answered 1, 2 or 3 please specify what needs to be improved_____________________________
____
____

10. For how many preadmissions did you supplement the form with a telephone call? _____________
Please describe why a phone call was necessary:____
____
____

11. General comments
____
____

REFERRAL FORM EVALUATION SURVEY

1. Please provide your name, email, organization, and position:
Name:____________________________________ Organization:_______________________________
Email:____________________________________ Position:____________________________________

2. Are you a referrer _________ or referral recipient _________?

3. How many of the new MSK referral forms did you complete/receive this week? ______

4. How many minutes on average did it take to complete each?________________minutes

5. How many referrals did you complete on other referral forms______________________
Why?____

6. Ease of Completion: Rate the ease of completion/review of this form: **(Low) 1 2 3 4 5 (High)**
If you rated the form as a 1,2, or 3 please describe where the difficulties lie: ______________________
____
____

7. Succinctness: To what extent do you feel information fields are succinct? **(Low) 1 2 3 4 5 (High)**
If you answered 1, 2 or 3, please describe what is redundant_____________________________________
____
____

8. Pertinence: Does the form request the information that is important? **(Low) 1 2 3 4 5 (High)**
If you answered 1, 2, or 3 please describe what elements need to be added or removed _____________
____
____

9. Objectivity: To what extent do you feel this form enables an objective description of the patient?
(Low) 1 2 3 4 5 (High)
If you answered 1, 2 or 3 please specify what needs to be improved______________________________
____
____

10. For how many referrals did you supplement the form with a telephone call? _________________
Please describe why a phone call was necessary:____
____
____

11. General comments
____
____

RESPONSE FORM EVALUATION SURVEY

1. Please provide your name, email, organization, and position:
Name:____________________________________ Organization:_______________________________
Email:____________________________________ Position:____________________________________

2. Are you a referrer _________ or referral recipient _________?

3. How many response forms did you complete/receive in total this week? __________

4. How many minutes on average did it take to complete/review each?___________minutes

5. Ease of Completion: Rate the ease of completion/review of this form: **(Low) 1 2 3 4 5 (High)**
If you rated the form as a 1,2, or 3 please describe where the difficulties lie: ______________________

6. Succinctness: To what extent do you feel information fields are succinct? **(Low) 1 2 3 4 5 (High)**
If you answered 1, 2 or 3, please describe what is redundant____________________________________

7. Pertinence: Does the form request the information that is important? **(Low) 1 2 3 4 5 (High)**
If you answered 1, 2, or 3 please describe what elements need to be added or removed _____________

8. Objectivity: To what extent do you feel this form enables an objective response?
(Low) 1 2 3 4 5 (High)
If you answered 1, 2 or 3 please specify what needs to be improved______________________________

9. For how many referral responses did you supplement the form with a telephone call? _________
Please describe why a phone call was necessary:____

10. Generalizability: To what extent do you believe this form could be used for other populations?
(Low) 1 2 3 4 5 (High) If you answered 1, 2, or 3 please describe why:________________________

11. General comments:

APPENDIX IV

PILOT BACKGROUND MATERIAL

PILOT INSTRUCTIONS
By November 15, 2004 all interorganizational joint replacement and hip fracture inpatient referrals to specialized, general or geriatric rehabilitation should be made as follows:

For Preadmission of Simple Elective Hip and Knee Replacements (all organizations) and Self Care program at Toronto Rehab Hillcrest Site.

- ✓ Use the GTA Rehab Network Preadmission Form. This form replaces existing preadmission forms.

Hip Fractures and Complex Joint Replacements

- ✓ Use the GTA Rehab Network Hip Fracture and Joint Replacements Referral Form. This form replaces the HCMT Form.
- ✓ Use this for all interorganizational inpatient referrals to general, specialized, and geriatric inpatient programs for hip fractures and joint replacements at pilot organizations (see below). Use of the new forms for non-pilot organizations depends on that organization's preference.
- ✓ Responders will complete a response form and fax it back to the referrer to inform of the referral decision. This should replace the telephone call.

NB: Please note that this is a pilot to test the revised forms. As you complete the forms you may note areas for improvement. Please record these and share them with the pilot lead at your organization

Pilot Leads By Organization

Suesan Way, Social Worker MSK Representative	Mt. Sinai Hospital
Debbie Galet, Case Manager	St. Michael's Hospital
Maria Martinez, Social Worker	University Health Network
Cathy Brandt, Manager Program Services	Toronto Rehab
Marie Grace Grossi, Professional Practice Leader	St. John's Rehab
Vilma Rusac, Care Coordinator MSK Rehab	West Park Health Centre
Connie Stamp, Clinical Coordinator	Providence Healthcare
Kim Sterling, Case Manager MSK Program	Bridgepoint Health
Guilda Theriault, Resource Nurse	William Osler
Cathy Cotton, Patient Care Director	Scarborough Hospital
	Baycrest Centre

Thank You for Participating in this Pilot!

APPENDIX IV

PILOT BACKGROUND MATERIAL

PILOT LEADER ROLES AND RESPONSIBILITIES

- **Educate:** Use the first week to introduce the idea and circulate the material. You have received two documents for this purpose. Post and circulate these.
  - Background document to explain the context of the initiative.
  - Instructions for use of the form that can be posted or circulated

- **Initiate:** Supply your team with the referral forms and the background information. You should have

  Preadmission Form: This form is to be used by the referrers in place of existing preadmission forms for simple joint replacements.
  Referral Form: This form is to be used by the referrers in place of the HCMT form for all hip fracture and complex joint replacement patient referrals to inpatient general, specialized, or geriatric rehabilitation.
  Response Form: This form should be completed by referral recipients for each referral made using the referral form for hip fracture and complex joint replacements to specialized, general, and geriatric inpatient rehabilitation.

- **Encourage:** Do not be discouraged if there is reluctance to use the new form. Resistance to new processes is healthy and appropriate.
  - Use the background document to help people see the context.
  - Remind people that this is a pilot and that we will be revising the forms based on feedback.

- **Implement:** Ensure that the form is used for all rehabilitation referrals by November 12, 2004 (end of week 2) and that all referrals to inpatient general, population specific or geriatric rehabilitation programs are made using the revised forms. Referral recipients should be requiring that referrals be made on the new forms.

- **Evaluate:** Please complete the enclosed evaluation surveys [preadmission, referral, and response]. Both the acute care providers and the rehab providers should evaluate all of the forms. In the final week, referral recipients will receive a special form to compare the match between the referral form description and the actual patient.

Calendar of Critical Dates

Date	Activity
November 1-12	Introduce the forms, provide background information, initiate use
November 15	Complete 1st evaluation survey set
November 26	Complete 2nd evaluation survey set
December 3	Complete 3rd evaluation survey set
December 10	Complete final evaluation survey set
December 15*	Providers will select 10 patients to compare referral to actual patients

*Further details on this activity will be provided closer to December.

Please do not hesitate to contact Tina Saryeddine, Project Manager/Senior Planner at 416-597-3422 x 3924 if you have any questions or concerns

APPENDIX IV

PILOT BACKGROUND MATERIAL

Background:
The HCMT referral form, currently used to make musculoskeletal (MSK) rehabilitation referrals has been only slightly modified since it was first introduced nearly 30 years ago. Organizations such as the Toronto ABI Network and the Toronto West Regional Stroke Network have worked diligently to develop and implement referral forms for their respective populations. The GTA Rehab Network is pleased to announce a pilot of MSK referral, response, and preadmission forms.

Rationale:
A referral form is more than paper. It gives each patient a fair and equitable chance to be accurately and objectively described and assessed. At a consensus session held in December 2003, providers from across the GTA felt that improved referral and response forms and protocols were essential not only at the patient level but also for monitoring and addressing access and waiting list issues. Following a critical assessment of the HCMT form, it was felt that our current form could be enhanced to adhere to the following principles.

- Facilitates Integration
- Transparent Disclosure
- Objectivity
- Evidence Based
- Flexible Standardization
- Ease of Completion
- Pertinence
- Comprehensiveness
- Fairness

In the future, we would like to automoate referral and response forms to track the characteristics and wait times of those patients who are accepted, declined, and wait listed for rehabilitation (see Figure 1 pg. 2)

Pilot Test Questions:
- Are we facilitating an accurate and appropriate description of the patient for referrers?
- Are we facilitating a simplified review and assessment of the patient for referral recipients?
- Are we minimizing subjective text entries used to describe or assess the patient?
- Are there elements missing from the form? Are there elements that are redundant?

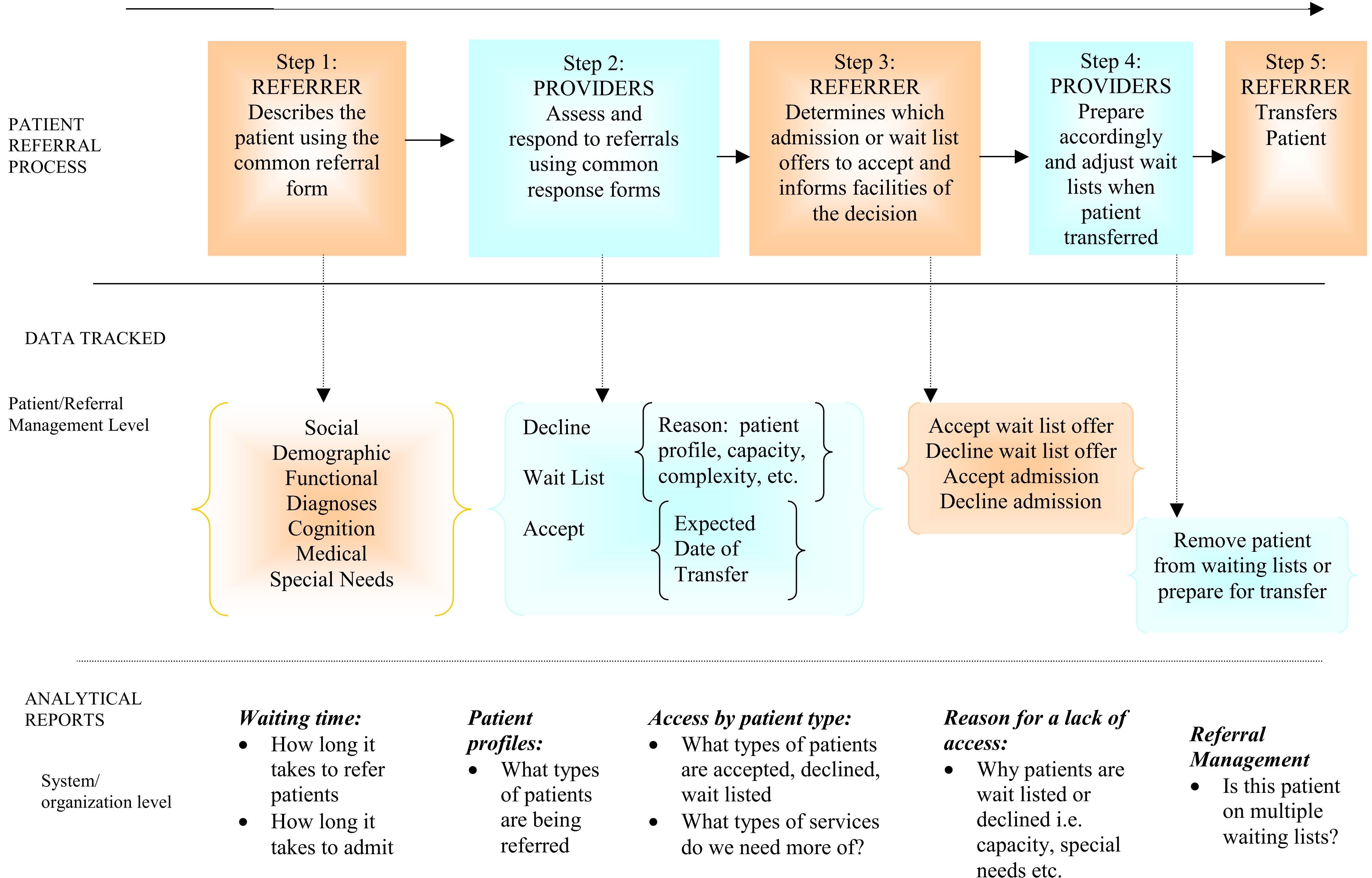
Duration:
The pilot project will last 6 weeks beginning November 1 and running to December 15 inclusive. The first two weeks will be used to become familiar with the forms. The remaining weeks will be used to test them. After the six-week pilot, the forms will be revised as per the feedback for ongoing use.

Approach:
Following the first two weeks, each of the acute care hospitals will continue to use the new referral form. At the end of each pilot week, they will assess the amount of time taken to complete the referral form and the extent to which they felt the forms contained the necessary or redundant information on the patient. A short questionnaire will be completed each week on the week's referrals. At the referral recipients' end, they will receive the new referral forms and comment on the extent to which the referral was complete and the extent to which there was redundant information. In the final week, providers will be asked to do an audit of 10 randomly selected patients to determine the extent to which the referral description accurately described the patient.

Participants:
Mt. Sinai Hospital, St. Michael's Hospital, and the University Health Network, Providence Healthcare, Bridgepoint Health, West Park, St. John's, Toronto Rehab, William Osler, and The Scarborough Hospital.

FIGURE 1: FUTURE VISION* OF ELECTRONIC REFERRAL SYSTEM

Every step is date stamped to record waiting times. Information on each step linked for each patient



*NB: This describes part of the vision only and is not at the point of implementation

APPENDIX V
Referral, Response & Preadmission Forms

- Authorization Form
- Preadmission Form
- Referral Form
- Response Form

AUTHORIZATION FOR RELEASE AND FAX TRANSMISSION
Of Patient Record and Referral or Preadmission Form

FAX TRANSMISSION

Fax From: Name: ________________________________ Phone/Pager: ______________
Organization: ________________________________ Unit: ____________________

Fax To:
- ❑ Baycrest 416-785-2317
- ❑ Bridgepoint 416-461-5499
- ❑ Providence 416-285-3759
- ❑ Other *(specify)*____________________
- ❑ St. John's 416-226-5406
- ❑ Toronto Rehab 416-537-3752
- ❑ West Park 416-243-8397
- ❑ Other *(specify)*____________________

Number of pages: __________ *(including fax cover and consent page)*

PATIENT CONSENT

A) Information Release

I ________________________________ hereby authorize ____________________________
Name of patient or substitute decision maker *Name of organization*

to release the following information on ______________________________________from the patient
Patient's Name

record, referral form or preadmission form for the purposes of determining eligibility for services to the organizations identified in the FAX TO box above.

Please check to indicate your consent to part A): Yes_____ No______

B) Use of Information From the Referral Forms for Research/System Improvement

I also understand and consent that information from the referral form, with the exception of any information that would identify the patient (i.e., name, address, health card number, postal codes, names of agents or substitute decision makers, etc.), may be used to produce reports and further research and system improvements.

Please check to indicate your consent to part B): Yes_____ No______

Individual providing consent:

Name of individual providing consent: ____
Relationship if not patient: ____
Signature: ____
Date of signature: Y/ ________ M/_________ D/_________
Date of expiration of authorization: Y/ ________ M/_________ D/_________

The information contained herein is confidential and no unauthorized person will have access to the information without the consent of the patient/client or substitute decision-maker.

REHAB PRE-ADMISSION FORM:
Elective Hip and Knee Surgery - Replacements and Revisions

Patient: Last name: ______________________ First name: ______________________

Health Card: Number: ______________________ Version: _____ **Date of Referral:** Y/ ____ M/____ D/____

Gender: ❑ Male ❑ Female **Date of Birth:** Y/ ____ M/____ D/____

Address: Number & Street: ______________________City:______________ Postal Code: ______________

Home Phone Number: ( ) ______________ **Accommodation Requested:** ❑ Standard ❑ Semi-Private ❑ Private

Insurance: Company Name: ______________________ Policy/Certificate & Group #: ______________________

Next of Kin/Emergency Contact: Name: ______________________Telephone: ______________________

Date of Surgery: Y/ ________ M/__________ D/__________ ❑ Date Unknown

Current Surgical Intervention:

	Hip Replacement	Knee Replacement	Revision of Hip Implant	Revision of Knee Implant	Pin and Plate	Hemiarthroplasty
Right	❑	❑	❑	❑	❑	❑
Left	❑	❑	❑	❑	❑	❑

Other: ____

Date Ready for Rehab/Self-Care: Y/ ________ M/__________ D/__________ ❑ Date Unknown ❑ Self Care

Primary Diagnosis: ❑ Osteoarthritis (right) ❑ Osteoarthritis (left) ❑ AVN ❑ RA ❑ Unknown ❑ Other: ______________

Past and relevant history:

Psychiatric: ❑ No ❑ Yes *(specify)*______________________________ ❑ Unknown

Medical: ❑ No ❑ Yes *(specify)*______________________________ ❑ Unknown

Surgical: ❑ No ❑ Yes *(specify)*______________________ Y/ _____ M/_____D/_____ ❑ Unknown
❑ No ❑ Yes *(specify)*______________________ Y/ _____ M/_____D/_____ ❑ Unknown

Secondary Diagnoses *(check all that apply)*

❑ Stroke/Acquired Brain Injury ❑ Cardiac *(specify)*______________________
❑ Diabetes Milletus ❑ Respiratory *(specify)*______________________
❑ Hypertension ❑ Unknown ❑ Other *(specify)*______________________

Height *(approximate)* ______________ ❑ Unknown **Weight > 250 lbs** ❑ Yes ❑ No ❑ Unknown

Language spoken *(if not English)*: ______________ **Interpreter required:** ❑ Yes ❑ No ❑ Unknown

Living Setting:

Prehospital: ❑ home ❑ community ❑ facility
Discharge: ❑ home ❑ community ❑ facility

Have discharge plans been discussed? ❑ Yes ❑ No

Physician/specialists involved in care of patient:

Name:______________________ Specialty: ______________________ Phone: ( )______________
Name:______________________ Specialty: ______________________ Phone: ( )______________
Name:______________________ Specialty: ______________________ Phone: ( )______________

Other Notes: ____
____
____

Referrer: Contact person: ______________________ Phone: ( ) ______________
Position:______________ Organization______________ Pager: ( ) ______________

The information contained herein is confidential. No unauthorized person will have access to the information without the consent of the patient/client or substitute decision-maker.

This page completed by: ***Page 1 of 1***

______________ ______________ ( ) ______________
Name *Discipline* *Telephone Number*

INPATIENT REHAB REFERRAL FORM FOR ORTHOPAEDIC CLIENTS

Tested for Hip Fracture, Hip Replacement, and Knee Replacement Patients
Also accepted for amputations, upper and lower extremity single fractures, and pelvic fractures

GENERAL INFORMATION

Date of Referral: Y/ _________ M/__________ D/__________

Patient: Last name: _______________________________________ First name: _________________________________

Health Card: Number: ____ Version: ____________

Date of Birth: Y/ _____M/______D/____ **Gender:** ❑ Male ❑ Female

Home phone number (______) _______________________ Postal Code: ________________

Address: ____

City: ____ Postal Code: ________________

Next of Kin/ Emergency Contact: ____ Telephone: (______) _______________________

Referrer's Contact: Contact person: ____ Phone: (______) _______________________

Position:____ Pager: (______) ______________________

Organization:____

Patient Location: ____ Patient Location Unit: ____________________

Date of Injury: Y/ _________ M/__________ D/__________ ❑ Date Unknown ❑ N/A

Date of Surgery: Y/ _________ M/__________ D/__________ ❑ Date Unknown ❑ N/A

Date Ready for Rehab: Y/ _________ M/__________ D/__________ ❑ Date Unknown

Accommodation Requested: ❑ Standard ❑ Semi-Private ❑ Private

Insurance: Company Name: ____

Policy Number or Certificate Number and Group Number: ____

Family Physician: Name: ____ Phone: (______) _______________________

Address: ____ Postal Code: _________________________

Attending Physician: Name: ____ Phone: (______) _______________________

Address: ____ Postal Code: _________________________

FUNCTIONAL INFORMATION

Patient/Client Name: ____

Height: __________ | **Smoker:**

Weight: _______ lbs | ❑ Yes ❑ No

**Physiotherapy/Occupational Therapy Notes: Please attach and ensure that the following are clearly articulated: Weight bearing status, Activity tolerance, Ability to follow instructions, Sitting Tolerance, Type of walker, and details of Prosthesis if applicable.*

Activities of Daily Living

Chewing:	Difficulty: ❑ Yes ❑ No	Dentures: ❑ Yes ❑ No		Pureed diet: ❑ Yes ❑ No	
Swallowing:	❑ Intact/regular diet	❑ Dental soft diet	❑ Minced diet	❑ Pureed diet	❑ Thickened fluids
Feeding:	❑ Independent	❑ Supervision required	❑ Needs partial assistance		❑ Total assistance
Dressing:	❑ Independent	❑ Supervision required	❑ Needs partial assistance		❑ Total assistance
Bathing:	❑ Independent	❑ Supervision required	❑ Needs partial assistance		❑ Total assistance
Incontinence:	❑ Not applicable	❑ Bowel	❑ Bladder	❑ Catheter	❑ Condom

Toileting plan initiated: ❑ N/A ❑ No ❑ Yes *(If yes, specify):*

Mobility

Transfers:	❑ mechanical lift	❑ 2-person	❑ 1 person	❑ supervision	❑ Independent
	❑ On bed rest	❑ transfer-aide *(specify):*			
Ambulation:	❑ fully ambulatory	❑ 2 person	❑ 1 person	❑ supervision	❑ Independent
	❑ mobility-aide	❑ crutches	❑ Cane	❑ walker *(specify type):*	

Limbs	Left:	Right:
Upper Extremity:	❑ Impaired ❑ No function ❑ Normal	❑ Impaired ❑ No function ❑ Normal
Lower Extremity:	❑ Impaired ❑ No function ❑ Normal	❑ Impaired ❑ No function ❑ Normal

Other limb involvement:____

Communication

Hearing:	❑ Adequate	❑ Adequate with hearing aid	❑ Impaired	❑ Unable to hear at all
Vision:	❑ Intact	❑ Adequate with glasses	❑ Impaired	❑ Unable to see at all
Language expression:	❑ Intact	❑ Basic needs only	❑ Uses gesturing	❑ Completely impaired
Language comprehension:	❑ Intact	❑ Follows basic instructions	❑ Impaired	

Language spoken: Interpreter required: ❑ Yes ❑ No

Cognitive Status

Orientation:	❑ Not tested	❑ Intact	❑ Impaired *(specify):*__________________
Attention:	❑ Not tested	❑ Intact	❑ Impaired *(specify):* __________________
Memory (short term):	❑ Not tested	❑ Intact	❑ Impaired *(specify):* __________________
Memory (long term):	❑ Not tested	❑ Intact	❑ Impaired *(specify):* __________________
Judgment:	❑ Not tested	❑ Intact	❑ Impaired *(specify):* __________________
Insight:	❑ Not tested	❑ Intact	❑ Impaired *(specify):* __________________

Mini mental score (if applicable):

Restraints

Type: ❑ None ❑ Pharmaceutical ❑ Magnetic ❑ Lap belt ❑ Wrist restraint ❑ Posey jacket

Other *(specify):*____

Reason: ❑ Safety e.g. at risk for falls ❑ Exit seeking ❑ Agitated ❑ Harm to self or others

Other *(specify):*____

Behavioural issues

❑ None ❑ Physical aggression ❑ Verbal aggression ❑ Inappropriate sexual behaviour

❑ Self abuse ❑ Wandering ❑ Other (please specify):______________________________

This page completed by (if not referral contact):

______________________ ______________________ (______)__________________

Name *Discipline* *Telephone Number*

SOCIAL INFORMATION

Patient/Client Name: ______________________________

Substitute Decision Maker/ Individual with Power of Attorney	❑ POA *(personal care)* ❑ POA *(finance)* ❑ SDM ❑N/A	Name: ______________________________ Home Phone : (______) ____________ Bus. Phone: (______) ____________ Relationship: ❑ Spouse/partner ❑ Daughter/son ❑ Parent ❑ Sibling ❑ Other

If substitute decision maker or power of attorney are not same individual, please complete this box	❑ POA *(personal care)* ❑ POA *(finance)* ❑ SDM ❑ N/A	Name: ______________________________ Home Phone : (______) ____________ Bus. Phone: (______) ____________ Relationship: ❑ Spouse/partner ❑ Daughter/son ❑ Parent ❑ Sibling ❑ Other

Public Guardian and Trustee:	❑ N/A	Name: ______________________________ Phone: (______) ____________ Client File #: ____________

Living Setting	**Home Alone**	**Home w/ Family/ Relative**	**Home Friends**	**Home Attendant**	**Complex Continuing Care**	**Nursing home**	**Retirement Home**	**Other**
Pre-hospital	❑	❑	❑	❑	❑	❑	❑	❑
Discharge	❑	❑	❑	❑	❑	❑	❑	❑

Have discharge plans post rehab been discussed?	❑ No ❑ Yes (specify)
Have discharge plans post rehab been arranged?	❑ No ❑ Yes (specify)

Family/support network information (who, how available, interaction, issues of concern)
Community services/support:
Relevant cultural considerations:
Insurance/legal involvement:
Other:

Substance use issues: ❑ Yes ❑ No

This page completed by (if not referral contact):

______________________ ______________________ (________)______________________
Name *Discipline* *Telephone Number*

MEDICAL INFORMATION

Patient/Client Name: ________________________________

Current Surgical Intervention:

	Hip Replacement	Knee Replacement	Revision of Hip Implant	Revision of knee implant	Pin and Plate	Hemiarthroplasty
Right	❑	❑	❑	❑	❑	❑
Left	❑	❑	❑	❑	❑	❑

Other: ________________________________

Past and relevant history: *Please respond no or yes if there is a past* ***relevant*** *history/complications (if yes, specify)*

Medical: ❑ No ❑ Yes

Psychiatric: ❑ No ❑ Yes

Surgical: ❑ No ❑ Yes

Primary Diagnosis

❑ Left Osteoarthritis ❑ Right Osteoarthritis ❑ Pathologic fractures ❑ AVN
❑ Left Hip fracture ❑ Right Hip fracture ❑ RA ❑ Other *(specify)*:____________

Secondary Diagnoses (check all that apply)

❑ Stroke/Acquired Brain Injury ❑ Cardiac (please specify): ❑ Respiratory (please specify)____________
❑ Diabetes Milletus ❑ Hypertension ❑ Other (please specify):____________

Weight bearing status

❑ As tolerated ❑ Partial________lbs ❑ Touch weight bearing ❑ Non weight bearing
Precautions and restrictions:____________ Time to become weight bearing:____________

Special Needs			*Specify:*
Oxygen:	❑ no	❑ yes	❑ intermittent ❑ continuous Rate: _______ Mode: _______
IV Lines:	❑ no	❑ yes	❑ medication ❑ hydration ❑ peripheral ❑ central
Dialysis:	❑ no	❑ yes	❑ peritoneal ❑ hemodialysis
Specialized wound/incision:	❑ no	❑ yes	Frequency of change: __________ Type of dressing: __________
Other (CPAP,Gtube, colost):	❑ no	❑ yes	Specify____________

Infection control issues			*Specify:*
Is patient MRSA positive	❑ no	❑ yes	❑ current ❑ past
Other (VRE, Acinobater etc)	❑ no	❑ yes	type: __________ ❑ current ❑ past
Is patient on antibiotics?	❑ no	❑ yes	type: __________ reason__________
Does patient need isolation?	❑ no	❑ yes	why: __________

Pharmacy:

Is the patient on any investigational drugs/study? ❑ no ❑ yes specify__________
Is the patient on methadone? ❑ no ❑ yes specify__________
Is the medication infused intravenously? ❑ no ❑ yes ❑ peripheral ❑ central
Do you anticipate high cost/atypical drugs for this patient? ❑ Unknown ❑ no ❑ yes specify__________

This page completed by (if not referral contact):

__________ __________ (______)__________
Name *Discipline* *Telephone Number*

I authorize the referral of this patient for inpatient rehabilitation

Name__________ Y/ ____ M/_____ D/_____

Physician's Signature__________

REFERRAL RESPONSE FORM AND FAX TRANSMISSION SHEET
Patients Declined

FAX TRANSMISSION

Fax To:

❑ University Health Network 416-603-5237 Attention: ______________________

❑ St. Michael's Hospital 416-864-6062 Attention: ______________________

❑ Mt. Sinai Hospital 416-586-8791 Attention: ______________________

❑ Other______________ Attention: ______________________
(specify)

Fax From: Name: ______________________ Phone/Pager:: ______________
Organization:______________________ Unit:: ______________

RESPONSE FORM FOR PATIENTS DECLINED

Re Patient: First Name: ______________ Last Name: ______________

Declined because of (please check all that apply):

❑ Cognitive issues (specify) ______________________

❑ Behavioural issues (specify)______________________

❑ Special needs (specify): ______________________

❑ Medical complexity (specify):______________________

❑ Other (specify)______________________

Comments:

____

____

____

____

____

____

____

The information contained herein is confidential and no unauthorized person will have access to the information without the consent of the patient/client or substitute decision-maker.

APPENDIX VI

PILOT TEST RESULTS

PREADMISSION SCORES

PREADMISSION	Number	Time	Other forms	Ease	Succinct	Pertinence	Objectivity	Use of phone
referral recipient	12	N/A	N/A	2	2	3	4	0
referrer	4	10	0	4	4	4	3	0
referrer	2	10	1	3	4	4	2	0
referral recipient	8	N/A	N/A	3	4	2	4	8
referral recipient		N/A	N/A					
referral recipient		N/A	N/A	4	4	4	4	0
referral recipient	3				5	4	5	
referral recipient	5	N/A	N/A	5	5	5	4	0
referrer	30	10	0	4	4	4	4	7
referral recipient	10	5	N/A		4	1	4	
referral recipient	10	5	UNK	4	4	3	4	
referrer	13	5	0	4	4	3	4	0
referral recipient	25	2	50	5	4	2	4	2
referral recipient	47	N/A	N/A	3		3		4
referral recipient	49		65	3				5
Total	**218**	**47**	**113**	**44**	**48**	**42**	**46**	**26**
# of responses	**12**	**12**	**13**	**12**	**11**	**12**	**12**	**10**
Average	**NA**	**NA**	**NA**	**3.7**	**4.4**	**3.5**	**3.83**	**NA**
Median	**NA**	**NA**	**NA**	**4**	**4**	**4**	**4**	**NA**
Range	**2 to 49**	**2 to 10**	**0 to 65**	**2 to 5**	**2 to 5**	**2 to 5**	**2 to 5**	**0-26**

APPENDIX VI
PILOT TEST RESULTS

PREADMISSION COMMENTS *Comments were requested only where a score of less than 4 out of 5 was given.

Succinctness
- referrer info is repeated at the end with person completing this form info.
- same as previously

Pertinence
- Emergency contact (next of kin), marital status, patient's phone number and family physician is information that is lacking and in our organization we 'input' this prior to patient's arrival.
- Need to add the following fields: pt's marital status, NOK info, family physician. This will cut down on the time pt's have to stay in admitting on day of admit.
- There is no place for pt's phone no, contact person (pt's), and religion - which is needed for St. John's.
- Add pt's home phone, N.O.K., marital status
- as per # 6, space for pt telephone, in emerg contact (name, telephone, relation), family physician. Perhaps for ease of data entry into our required fields, primary diagnosis and current surgical intervention should be in much closer proximity.

Objectivity
- Need to have more room for rehab goals
- No room to explain what rehab goals are and what care is required.
- I think the medical hx. Is important to give an idea of pt's understanding and premorbid conditions. Gives a clearer description.
- not applicable to this position

Phone
- Incomplete information as outlined above. In addition, the pre-admit forms were incomplete missing some of the following information: lacking primary diagnosis, past medical history, patient's address, no surgery date, no rehab-ready date, no indication of which procedure was done (TKR vs THR)
- Missing information, incorrrect sx date
- Did not qualify for our preadmit program; requested full application be submitted after surgery
- Diagnosis and/or procedure not entered; date of sx/date ready for rehab missing; not a candidate for our preadmission program; patient's home missing

General
- Some of the forms use small ovals for response-difficult to see. Large squares preferred.
- Under Past & Relevant hx - not enough room under previous surgeries. Good forms - some reformatting might help make more room for writing
- The form gives a good snapshot of the pt, however, fields need to be added to minimize the time the pt is in admitting when they come in.
- I like the forms as I feel I am providing a more detailed description of the patients. I think contact (referrer info) is repeated at the end with person completing this form.
- 47 applications received, only 4 of them were on the new form.

APPENDIX VI
PILOT TEST RESULTS

REFERRAL FORM SCORES

Referral Scores	Number of referrals	Time required	Other forms	Ease	Succint	Pertinence	Objective	Phone
referral recipient	12	N/A	N/A	2	2	3	4	0
referrer	4	10	0	4	4	4	3	0
referrer	2	10	1	3	4	4	2	0
referral recipient	8	N/A	N/A	3	4	2	4	8
referral recipient		N/A	N/A					
referral recipient		N/A	N/A	4	4	4	4	0
referral recipient	3				5	4	5	
referral recipient	5	N/A	N/A	5	5	5	4	0
referrer	30	10	0	4	4	4	4	5-7
referral recipient	10	5	N/A		4	1	4	
referral recipient	10	5	UNK	4	4	3	4	
referrer	13	5	0	4	4	3	4	0
referral recipient	25	2	50	5	4	2	4	2
referral recipient	47	N/A	N/A	3		3		4
Total	**85**	**47**	**51**	**41**	**48**	**42**	**46**	**14**
Number of responses	**12**	**7**	**5**	**11**	**12**	**13**	**12**	**10**
Average where applicable	**NA**	**7**	**NA**	**3.42**	**4.00**	**3.23**	**3.83**	**NA**
Median	**NA**	**NA**	**NA**	**4**	**4**	**3**	**4**	**NA**
Rage where applicable	**2 to 47**	**2 to 10**	**0 to 50**	**2 to 5**	**2 to 5**	**1 to 5**	**2 to 5**	**0 to 7**

APPENDIX VI
PILOT TEST RESULTS

REFERRAL COMMENTS *Comments were requested only where a score of less than 4 out of 5 was given.

Ease of completion:
- Familiarity - just need additional time to know where the information needs to be placed.
- I found time a factor as there were 6 pages to complete. I seemed to spend a lot of time repeating info such as PT's name on top & bottom, repeating referrer's with phone # and then again at the bottom as person completing the form
- Lack of familiarity
- Does not flow well, no place for addressograph, tolerance section difficult to understand and complete

Recommendation 1: Add room for addressograph *Recommendation 2: Remove PT's name and number from either top or bottom of each page* *Recommendation 3: Reconsider flow of information* *Recommendation 4: Clarify tolerance section OR attach physio/notes*

Succinctness
- Too much room for PDA, SDM - one list to check the role and then the address field would be better.
- Exercise Tolerance - written on PT notes, all I do is transcribe yet I sent the PT note as well.
- I found I was having to flip back and forth in the computer for info. Suggest ADL's, communication, cognitive status together
- Especially when properly filled out. At times there are still blank areas in the forms.
- Missing info: contact, phone #s, insurance info

Recommendation 1: Addressograph *Recommendation 3: Reconsider flow of information* *Recommendation 4: Clarify tolerance section OR attach physio notes* *Recommendation 5: For PDA and SDM have check boxes to identify role and remove lines*

Pertinence:
- SW do not fill in P.O.A. SDM should be replaced with next of kin or emergency contact, pts home phone, marital status
- Need to add more room for meds, phone number (demographics)
- Info about preadmit level of mobility and assessment. Physio re expectation if appropriate for preadmit simple joint replacement
- Needs more direct questioning on rehab progress and participation (ex. Yes/no questions)

Recommendation 1: Addressograph *Recommendation 3: Reconsider flow of information* *Recommendation 4: Clarify tolerance section OR attach physio notes* *Recommendation 5: For PDA and SDM have check boxes to identify role and remove lines*

APPENDIX VI
PILOT TEST RESULTS

Recommendation 6: SDM should be replaced with next of kin or emergency contact, patient's home phone, marital status

Objectivity
- If all categories filled out.

Reasons for using telephone
- Needed more medical information or pt info not filled out correctly.
- They were the old preadmit form.
- Called to clarify missing information
- Very busy form. Lack of familiarity.
- Called to clarify medical history
- Additional physio etc. information was needed plus updated rehab information to advocate for the patient.

Recommendation 1: Addressograph
Recommendation 3: Reconsider flow of information
Recommendation 7: Add room for medical/revise formatting

General Comments
- I do not think that the word "Geriatric" should be part of the title as more 1st-time fractures are sent rather then complex MSKs
- Universal referral is time saving as it can be sent to several rehab programs once completed.
- Current OT/PT reports not always included. Some categories left blank.
- This process slowed our units patient movement down. Also created a workload issue. My biggest concern is that many pt's who were appropriate for preadmit Simple Elective Hip and Knee replacements who previously went through the simple program now have to wait longer
- Faxing bed confirmation did not ensure patient was ready to transfer. Still need MT #s & info from me. I feel "estimated adm. date" will still require phone call. Speaking to someone live will omit less confusion/errors/questions.
- Great form, contact information & phone # for pt is important. Insurance info not always on form.
- Form needs to reflect rehab goals, progress, participation in more detail. Form needs a place to address pts baseline status including social, physical, etc.

Recommendation 1: Add room for addressograph
Recommendation 2: Remove PT's name and number from either top or bottom of each page
Recommendation 3: Reconsider flow of information
Recommendation 4: Clarify tolerance section OR attach physio/notes

- Comments were only requested where improvements could be made, hence the absence of affirmations in the comments. Quality was assessed using the numerical indicators.

APPENDIX VI

PILOT TEST RESULTS

RESPONSE FORM SCORES*

RESPONSE SCORES								
Type of response	**number**	**time**	**ease**	**succint**	**pertinent**	**objectivity**	**telephone**	**generalizability**
referral recipient	13	5	4	4	3	5	1	4
referral recipient	11	5	4	5	3	4	1	3
referral recipient	3	1	5	5	5	5	0	5
referral recipient	10	3	4			4	5	
referral recipient	5-10	2	4	4		4		
referral recipient	3	10	3	3	3	4	all	2
referral recipient	6	10	3	3		4	0	
referral recipient	4	15	4	4	4	4	0	4
Total (Sum)	**32**	**51**	**31**	**28**	**18**	**34**	**7**	**18**
# of responses	**8**	**8**	**8**	**7**	**5**	**8**	**7**	**5**
Average	**4**	**NA**	**3.88**	**4**	**3.6**	**4.25**	**NA**	**3.6**
Median	**NA**	**NA**	**4**	**4**	**3**	**4**	**NA**	**NA**
Range (If applicable)	**5 to 13**	**1 to 15**	**3 to 5**	**3 to 5**	**3 to 5**	**4 to 5**	**NA**	**NA**

APPENDIX VI
PILOT TEST RESULTS

RESPONSE COMMENTS *Comments were requested only where a score of less than 4 out of 5 was given.

Ease of completion
- We have to find out the fax # and we cannot always give an appropriate estimate.
- Shaded areas difficult to read (category headings). Diagnosis & surgery/type of injury/# should be in same area of medical section. Insufficient social info, i.e. type of accomodation/stairs/functional ability

Succinct
- I need time to adjust to the format (why are we coming up with words like succinct?)

Pertinence
- mobility distance
- accepted & admitted by exception / accepted & wait listed by excepetion - I would not.
- missing a lot of info we need to process

Phone Call
- did not receive update
- wait for update
- bed offers made
- need a lot of demographic info - and fax #'s

Generalizability
- Neuro could use pt functional level
- I don't know
- Each program has specific information we need
- Do not know.

General comments
- If response would be a form already in referral pkg.
- This allowed me to plan more efficiently. I found this was very helpful as it saved a call. I like knowing pt's accepted or not in a timely manner, wait time, and reason if not accepted.
- Our admitting does acceptance/decline letter already - redundant form in this light - more work for me.
- I really think this is not a good use of time to have to fill out the response form. I think a phone call would be sufficient. If a facility sends more than 1 referral we have to fill out a response form for each one.
- We are missing demographics.

APPENDIX VI
PILOT TEST RESULTS

- None at present

Discussion Question1: *How important is it to have a record of referral responses? What other methods exist to collect information on patients declined? What other mechanisms can be used for transparency and accountability purposes?*
Discussion Question2: *Does the task group recommend continued use of the response form or deferral until an electronic means becomes available?*
Recommendation 1: Include list of all relevant fax numbers on the form itself
Recommendation 2: Make a recommendation that the response form use be deferred