

# **ALC Survey 2006:**

## **Mapping the way to targeted solutions**

**October 2006**

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## EXECUTIVE SUMMARY

Since its inception in late 1999, the GTA Rehab Network has taken a focussed approach to identify and address issues related to patients waiting for inpatient rehab in Alternate Level Care (ALC) beds in acute care. At the request of the Ontario Ministry of Health and Long-Term Care (MOHLTC), the Network conducted a series of snapshots in 2003 to obtain information on ALC patients awaiting inpatient rehabilitation. Data findings from these surveys pointed to the need for improvements in referral processes to optimize patient flow from acute care to inpatient rehabilitation. In response to these findings, the GTA Rehab Network developed and implemented a number of resources to support the timely transfer of patients to rehabilitation, including a set of guidelines to standardize the rehab referral process across the GTA.

In the fall of 2005, the MOHLTC Transformation Agenda directed acute care hospitals to decrease ALC days. As part of the Network's strategic focus on improving service delivery and access and to help members of the GTA Rehab Network work towards this goal, the Network conducted a review of patients waiting for rehab in ALC in three acute care hospitals within the Toronto Central LHIN boundary in February 2006. The survey captured information on the types of patients waiting for rehab, their medical complexity and total length of stay in ALC, as well as information on when referrals were submitted relative to ALC designation and how quickly rehab hospitals responded to referrals. The findings of the survey have been analyzed and used to identify and implement targeted solutions.

While it is recognized that a broad-based, system-wide approach that includes consideration of all elements contributing to ALC days is required to fully understand the complexities underlying ALC issues (e.g. factors precipitating acute care admissions, availability of health resources and support services, bed capacity etc.), the survey represents one approach to developing strategies in partnership with the Network's acute care and rehab partners to reduce the number of ALC days for patients awaiting inpatient rehabilitation in acute care.

### Approach:

The ALC survey was conducted in partnership with the Toronto Central West Emergency Network from February 6 – 22, 2006 at St. Michael's Hospital, St. Joseph's Health Centre and the University Health Network under the direction of the GTA Rehab Network's ALC Task Group (see Appendix B). Drawing on the findings of the 2003 ALC surveys which highlighted that 88% of patients waiting for rehab in ALC were in the Toronto region - more than half of whom waiting in the downtown acute teaching hospitals - the Toronto region was chosen as the focus of the review. An ALC data collection tool (see Appendix C) was developed in consultation with members of the Task Group to collect information about:

- patient characteristics
- primary diagnosis
- special needs
- type and intensity of rehab needed
- total length of stay in ALC

The survey also included data elements to evaluate adherence to the benchmarks established in the GTA Rehab Network's *Inpatient Rehab Referral Guidelines* implemented in the fall of 2005 (see Appendix D). The guidelines establish benchmarks for the timing of rehab referrals, number of rehab referrals to be submitted and timing of response to referrals.

At the end of the data collection period, the surveys were couriered to the GTA Rehab Network for data analysis.

## Key Findings:

Patient Profile: A total of 69 surveys were analyzed. The average age of all patients was 71, the majority (61%) of whom were female. The largest rehab population groups waiting in ALC as determined by primary rehab need were:

- Geriatric (43%)
- Stroke (16%)
- MSK (13%)
- ABI, Neurology and Cardiac (each 7%)

Length of Stay in ALC: Longest *total* ALC days were seen in descending order in the following rehab population groups:

- Geriatric (365 days)
- Stroke (79 days)
- Neurology (70 days)
- MSK (61 days)
- ABI (58 days)

Complex/Special Needs: The data were analyzed to determine the complexity of patients in ALC with respect to medical, social and housing needs. At least one or more special medical need was present for 42% of patients, with wound care as the most frequently cited special need. No patients were homeless and all patients had some level of social support. No patients required a sitter or supervision.

### Referral Patterns:

- 75% of referrals were submitted for regular rehab with an average length of stay in ALC of 9 days
- 25% of referrals submitted were for Low Tolerance Long Duration or Pre-rehab with an average length of stay in ALC of 27 days

Referral Processes: The Network's *Inpatient Rehab Referral Guidelines* establish benchmarks for the timing of rehab referrals (before ALC designation), number of rehab referrals to be submitted (minimum two) and timing of response to referrals (within two business days). The results of the ALC survey indicate that these benchmarks are not being met.

- For 33% of patients, 6% had no rehab referral submitted and 27% had one rehab referral submitted.
- Forty-two percent of referrals were submitted after ALC designation; of these 28% were sent three or more days after ALC designation.
- For 63% of referrals, the benchmark for timing of response to referrals was not achieved. No response was sent for 23% of these referrals. For 9% of referrals, the response was sent more than 10 days after the referral was sent and for 31% of these referrals, the response was received 3-10 days after the referral was sent.

## Next Steps:

The ALC survey conducted in February 2006 provides qualitative and quantitative information about patients waiting for inpatient rehabilitation in ALC. From the data analysis, key areas have been identified and targeted solutions have been developed to reduce ALC days for patients waiting for inpatient rehabilitation in acute care.

**i) Referral Inefficiencies**

Referral inefficiencies (i.e. timing of referrals, the number of referrals submitted and response to referrals) contribute considerably to length of stay in ALC. Benchmarks established in the Network's *Inpatient Rehab Referral Guidelines* are not being met. The identification of factors that contribute to ALC days (e.g. referral inefficiencies, management of special needs) points to the need for ongoing monitoring of patient access and flow from acute care to inpatient rehabilitation through an integrated approach.

**Targeted Solution:** To further enhance the efficiency of patient movement from acute care to rehab, the Network is moving forward with the development of a common rehab referral form building on the work from previous Network initiatives.

Overall findings of the ALC survey and organization-specific results have been circulated to Network members. All Network members are encouraged to use the findings of the survey to review their organizational processes for ALC designation, rehab referral submissions and response processes to achieve benchmarks established in the Network's *Inpatient Rehab Referral Guidelines*. The data collection tool used in the survey has been included in the Appendix section (Appendix C) and may be modified as needed to assist organizations with their own review process.

The GTA Rehab Network will convene a new standing committee, the Patient Access and Flow Committee, comprised of front-line referrers and receivers to monitor and identify operational system issues affecting patient transfers from acute care to inpatient rehab. The committee structure will provide the opportunity for representatives from acute care, freestanding rehab hospitals and community organizations to identify common issues affecting patient transfers, develop collaborative solutions and share best practices to reduce ALC days.

**ii) Geriatric Rehab**

Patients waiting for geriatric rehab represented the largest rehab population group by far in ALC with the longest total number of ALC days (365). Referral inefficiencies were present for almost all of these patients. Referrers indicate that they often have difficulty determining where to refer these patients and may not be accessing all available rehab options.

**Targeted Solution:** The Network, with the assistance of a contracted consultant, is working in partnership with the Regional Geriatric Program of Toronto and other content experts to explore barriers to geriatric rehab and increase clarity about where to refer geriatric patients for rehab, including those deemed "medically complex." Through this initiative, clear definitions and criteria for terms including "geriatric," "frail" and "medically complex" and the key components of rehabilitation required for these patients will be defined. A model for centralizing the geriatric rehab referral process, while supporting existing organizational relationships, will be explored. This initiative will include rehab programs provided across members of the GTA Rehab Network.

This initiative is part of the broader work that is being done concurrently by the Rehab Definitions Advisory Committee to develop common definitions that incorporate evidence-based parameters for other rehab programs. Standardization of programming will enhance our understanding of differences across programs, promote consistency and equitable access to rehab services and ensure a standard of care in rehab services.

**iii) Special Needs**

Forty-two per cent of patients had one or more special medical need. The most frequently cited special need was wound care.

**Targeted Solution:** The GTA Rehab Network has conducted key informant interviews to increase the understanding of wound care management in rehab hospitals and to identify potential areas of partnership between acute care and rehab hospitals to facilitate transfer to inpatient rehabilitation. Suggested strategies to support the transfer of patients with wound care needs to inpatient rehab include: cost-sharing of supplies and equipment to reduce the financial burden placed on rehab hospitals; sending patients from acute care with a few days supply of dressings to avoid delays in transfer while individualized dressings are ordered in rehab; improved communication through detailed treatment plans for wound care management; and continued efforts to minimize the development of wounds in acute care. Implementation of these and other strategies will be explored further with the Patient Access and Flow Committee.

## 1.0 INTRODUCTION

In 1989, the Canadian Institute for Health Information (CIHI) introduced the concept of Alternate Level of Care (ALC) to describe patients who have completed their acute care phase of treatment and are awaiting an alternate level of care.<sup>1</sup> By doing so, statistical information on true acute care patients can be separated from information on non-acute patients in acute care beds. Of particular interest to the GTA Rehab Network are the patients in ALC who are waiting for transfer to inpatient rehabilitation. Since its inception in late 1999, the GTA Rehab Network has engaged in a number of activities to identify and quantify who these patients are and develop system-wide solutions to reduce the length of stay in ALC for these patients.

In the spring of 2003, the GTA Rehab Network, at the request of the Ontario Ministry of Health and Long-Term Care (MOHLTC), conducted a series of five ALC snapshots to obtain information on patients waiting for inpatient rehabilitation in acute care during the Severe Acute Respiratory Syndrome outbreaks (SARS I & II).<sup>2</sup> Analysis of these snapshots conducted across hospitals in the GTA determined that 88% of ALC patients waiting for rehabilitation were waiting in Toronto region hospitals, the most prevalent of whom were patients waiting for musculoskeletal, stroke/neurology, geriatric and acquired brain injury rehab. Data findings also pointed to the need for improvements in referral processes to optimize patient flow and access to inpatient rehabilitation.

In response to these findings, the GTA Rehab Network developed and implemented a number of resources to support the timely transfer of patients to rehabilitation. These include: *Rehab Finder*, a web-based resource with detailed admission information on inpatient, outpatient and community-based rehab programs/services; *Musculoskeletal (MSK) Referral Form*, a common rehab referral form to streamline the referral process for patients who require orthopaedic rehab; and *Inpatient Rehab Referral Guidelines*, to standardize the rehab referral process across the GTA. A detailed summary of Network activities to reduce ALC days can be found in Appendix A.

In the fall of 2005, the MOHLTC Transformation Agenda directed acute care hospitals to decrease ALC days as part of an accountability process. As part of the Network's strategic focus on improving service delivery and access and to help members of the GTA Rehab Network work towards this goal, the Network conducted a focused review of patients waiting for rehab in ALC in three acute care hospitals within the Toronto Central LHIN boundary in February 2006. The survey captured information on the types of patients waiting for rehab, their medical complexity and total length of stay in ALC, as well as information on when referrals were submitted relative to ALC designation and how quickly rehab hospitals responded to referrals. The findings of the survey have been analyzed and used to identify and implement targeted solutions.

While it is recognized that a broad-based, system-wide approach that includes consideration of all elements contributing to ALC days is required to fully understand the complexities underlying ALC issues (e.g. factors precipitating acute care admissions, availability of health resources and support services, bed capacity etc.), the survey represents one approach to developing strategies in partnership with the Network's acute care and rehab partners to reduce the number of ALC days for patients awaiting inpatient rehabilitation in acute care.

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<sup>1</sup> CIHI Discharge Abstract Data Abstracting Manual, Chapter 10:1 – 10, April 2003.

<sup>2</sup> See GTA Rehab Network report, *Analysis of Alternate Level of Care (ALC) Snapshots: Patients Awaiting Rehabilitation in ALC and Inpatient Rehabilitation Capacity*, 2004.

## 2.0 APPROACH

The ALC survey was conducted in partnership with the Toronto Central West Emergency Network from February 6 – 22, 2006 at St. Michael's Hospital, St. Joseph's Health Centre and the University Health Network under the direction of the GTA Rehab Network's ALC Task Group (see Appendix B). Drawing on the findings of the 2003 ALC surveys which highlighted that 88% of patients waiting for rehab in ALC were in the Toronto region - more than half of whom waiting in the downtown acute teaching hospitals - the Toronto region was chosen as the focus of the review. The three participating hospitals represent half of the acute care hospitals within the Toronto Central LHIN boundary.

An ALC data collection tool (see Appendix C) was developed in consultation with members of the Task Group to collect information about patient characteristics; primary diagnosis; special needs; type and intensity of rehab needed; and total length of stay in ALC. The survey contained no identifying patient information. The survey was piloted at St. Joseph's Health Centre for one week to ensure that the survey captured all relevant data elements and to test ease of administration.

The survey also included data elements to conduct an evaluation of the GTA Rehab Network's *Inpatient Rehab Referral Guidelines*, which were implemented in the fall of 2005 (see Appendix D). The guidelines establish benchmarks for the timing of rehab referrals (before ALC designation), number of rehab referrals to be submitted (minimum two) and timing of response to referrals (within two business days). The guidelines also delineate response categories to facilitate communication between rehab and referring hospitals.

Each of the participating organizations designated key leads within their organization to oversee the administration of the survey. Data was obtained over a two-and-a-half week period on 69 patients waiting for rehab in ALC beds. At the end of the data collection period, the surveys were couriered to the GTA Rehab Network for data analysis.

### 3.0 FINDINGS

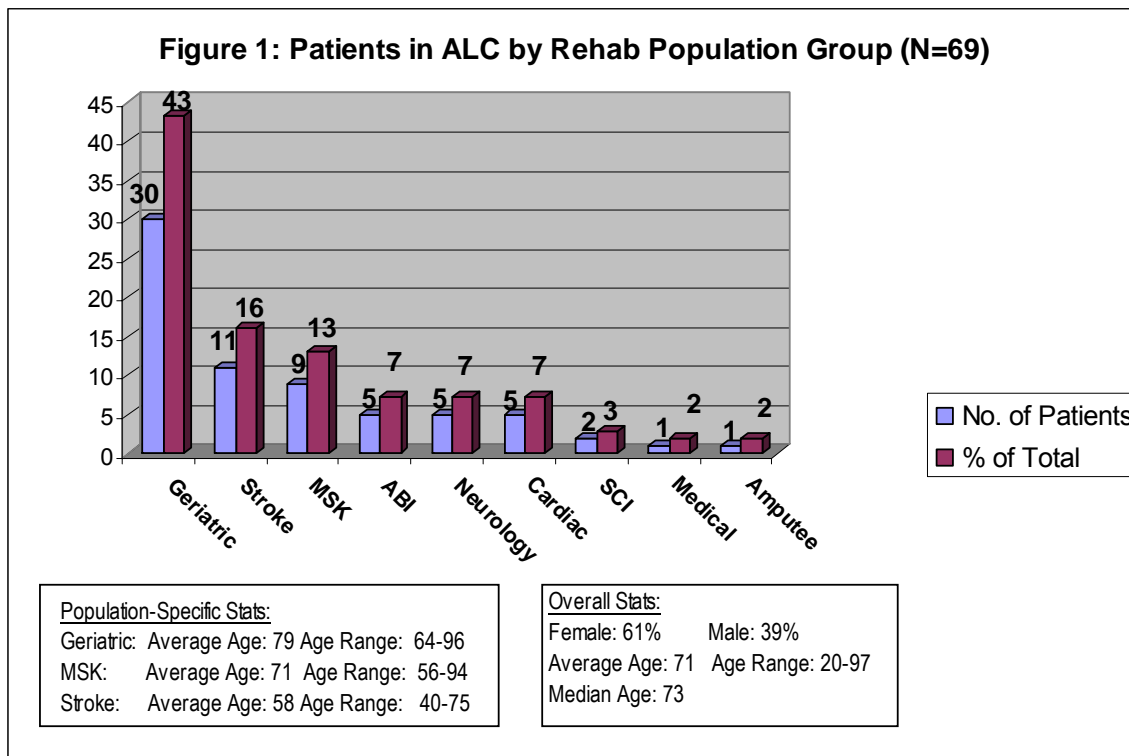
#### 3.1 Patient Profile

The largest rehab population groups waiting in ALC as determined by primary rehab need<sup>3</sup> were:

- Geriatric (43%)
- Stroke (16%)
- MSK (13%)
- ABI, Neurology and Cardiac (each 7%)

The majority of patients were female (61%) and the average age of all patients was 71 (Median Age: 73; Age Range: 20-97) (Figure 1).

The majority of patients (N=52 or 75%) were referred to regular stream rehab. The remaining 17 patients (25%) were referred to Low Tolerance Long Duration (LTLTD) rehab (N=13) or Pre-rehab programs (N=4).<sup>4</sup>



<sup>3</sup> Assignment of rehab population group is determined by acute care referrers according to the type of rehab program required by the patient rather than primary diagnosis in itself.

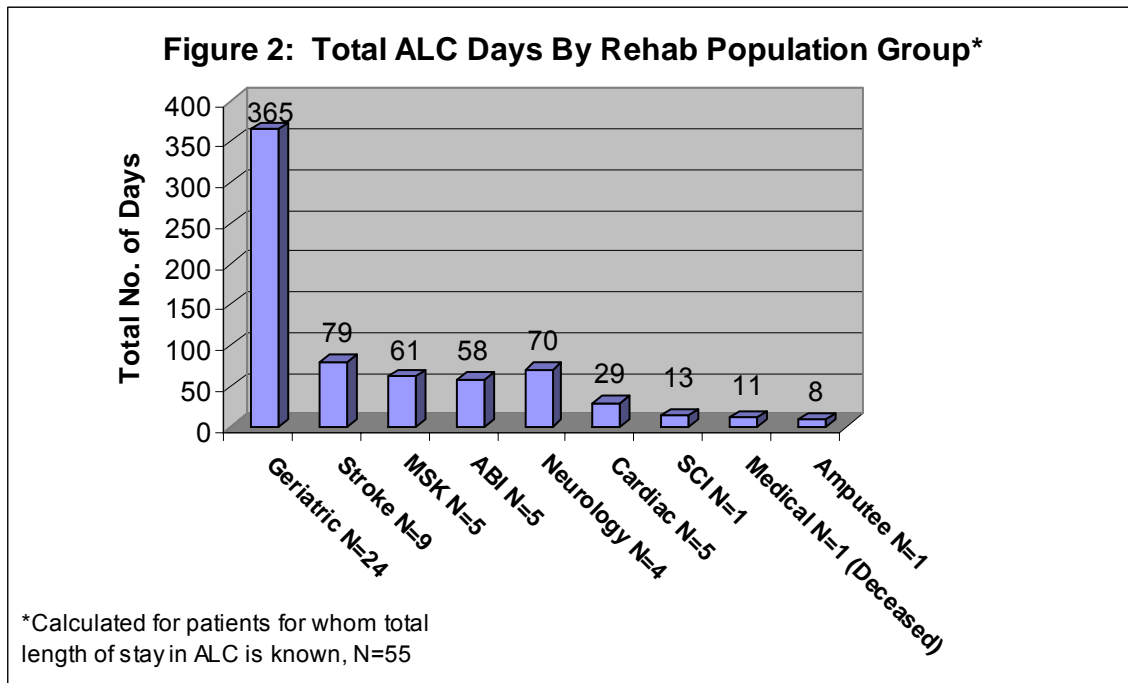
<sup>4</sup> Regular stream inpatient rehab is suitable for patients who are able to participate in an intensive interdisciplinary rehab program. LTLTD inpatient rehab is suitable for individuals who require a slower-paced rehab program for a longer duration to maximize rehab potential. Pre-rehab is suitable for patients who require treatment to recondition/strengthen patients in preparation for inpatient rehabilitation. (GTA Rehab Network Rehab Definitions Conceptual Framework, 2006) Determination of the type and level of intensity of rehab for patients from particular rehab population groups (e.g. Acquired Brain Injury, Geriatric, Stroke etc.) is based on the rehabilitation needs of the patient.

### 3.2 Length of Stay in ALC

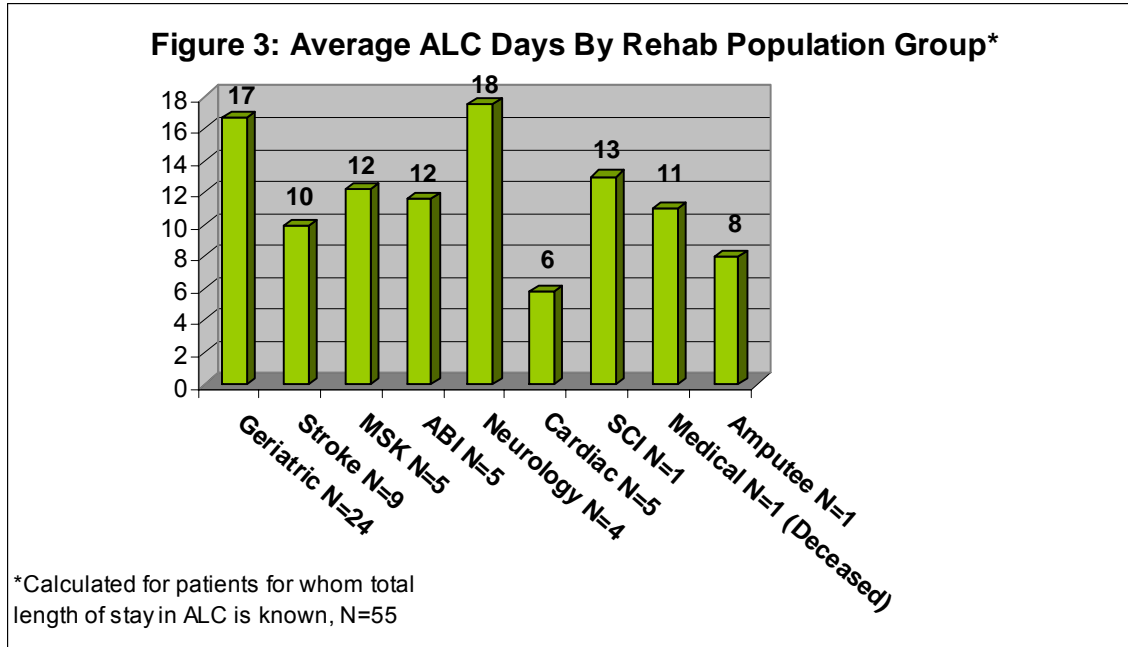
Longest *total* ALC days were seen in descending order in the following rehab population groups: (Figure 2)

- Geriatric (365 days)
- Stroke (79 days)
- Neurology (70 days)
- MSK (61 days)
- ABI (58 days)

Total ALC length of stay was calculated only for patients who were discharged during the survey period (N=55). Although the majority of these patients (84%, N=46) were transferred to an inpatient rehabilitation program, 11% of patients (N=6) referred for rehab were discharged directly home from ALC instead of going to inpatient rehab. These were primarily patients waiting for geriatric rehab. Of the remaining three patients, two were repatriated to local acute care community hospitals and one patient died.



The *average* length of stay in ALC for patients discharged during the survey period is presented in Figure 3. The data were also analyzed to determine differences in length of stay in ALC for patients referred to regular stream versus low tolerance long duration (LTLTD) rehabilitation. The average length of stay was considerably shorter for patients referred to regular stream rehab (9 days) than LTLTD rehab (27 days).



Patients Not Discharged During Survey Period: There were 14 patients who were not discharged during the survey period from the following rehab population groups:

- Geriatric 43% (N=6)
- MSK 29% (N=4)
- Stroke 14% (N=2)
- Neurology 7% (N=1)
- Spinal Cord Injury (SCI) 7% (N=1)

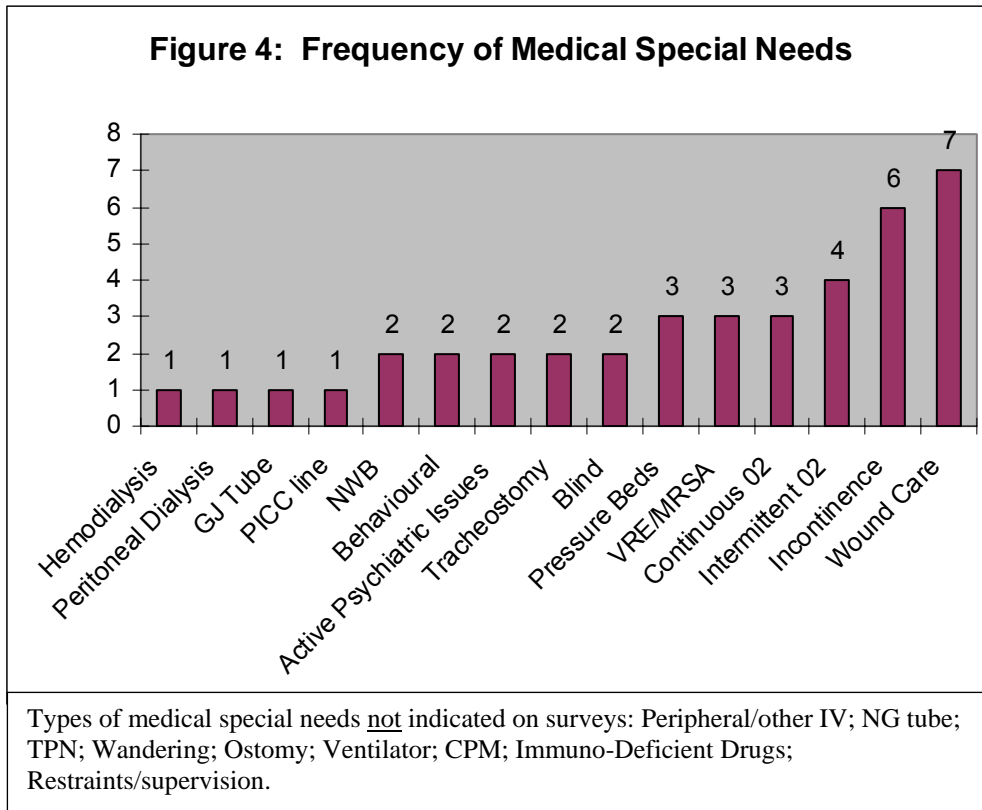
Of these 14 patients, the majority (71%) had been designated as ALC for 20 or more days at the end of the survey period (Range = 7 – 142 days; without 142 day outlier, Range = 7 – 48 days). The average number of ALC days (without outlier) was 29 days. By the end of the survey period, referrals for three patients had been accepted and waitlisted.

### 3.3 Complex/Special Needs

The data were also analyzed to determine the complexity of patients in ALC with respect to their medical, social and housing needs. Patients' social and housing situations were not a contributing factor to length of stay in ALC. No patients were homeless and all patients had some level of social support. The inability to follow instructions was also not a barrier to accessing rehabilitation; all patients for whom data were available (98%) were able to follow commands. No patients required restraints or a sitter.

Information about the special medical needs of patients was also collected (see data collection tool for listing, Appendix C). Forty-two percent of patients (N=29) had one or more special medical need and the most frequently cited special medical need was wound care (Figure 4). Of the 29 patients who had a special medical need, the majority, 20 patients, had only one special medical need.

The extent to which the presence of special medical needs as a sole contributing factor to delayed transfer to inpatient rehab could not be determined. There were also referral inefficiencies<sup>5</sup> present for most of these patients. However, the presence of a special medical need was responsible for delayed admission to rehab in one situation in which the referrals submitted on behalf of one patient for regular stream stroke rehab were denied because of the presence of a tracheostomy.



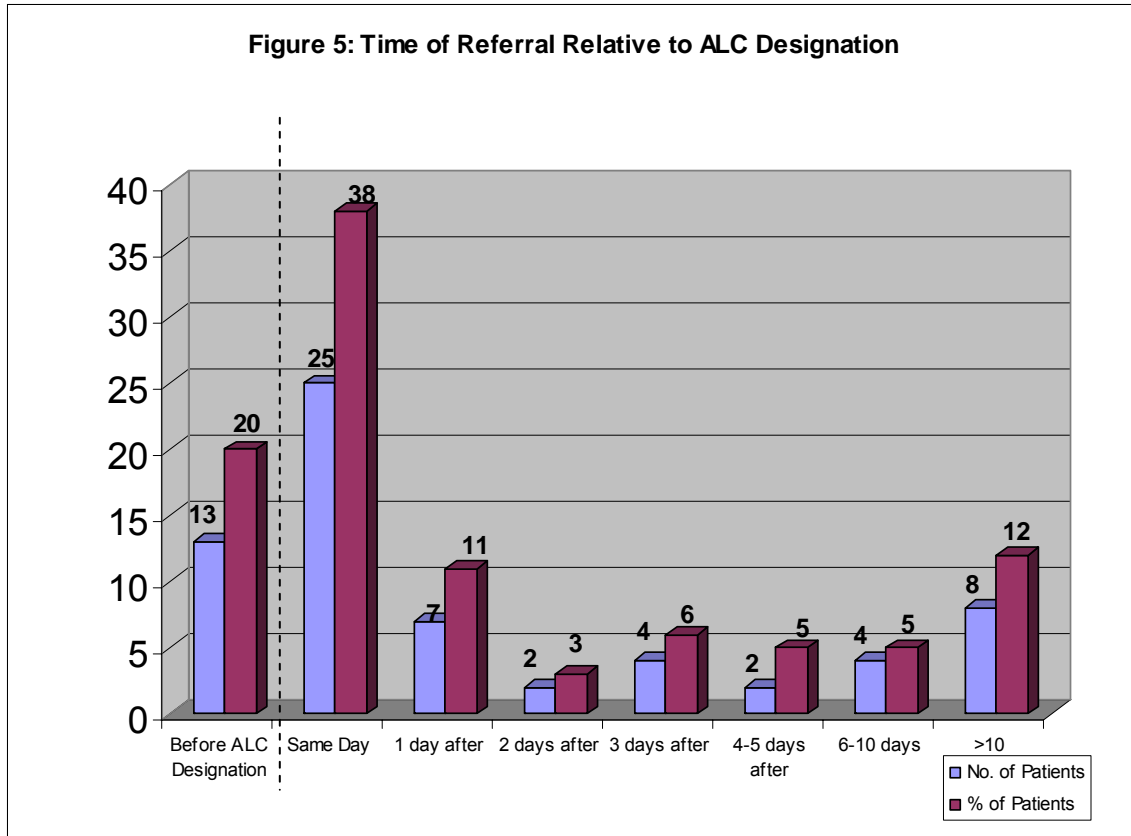
### 3.4 Referral Patterns and Processes

In addition to increasing our understanding of the types of patients waiting for rehab in ALC, the survey was also used to gain information about referral practices as measured by adherence to the benchmarks established in the Network's *Inpatient Rehab Referral Guidelines*. The guidelines were developed in consultation with acute care and rehab hospitals and implemented in 2005 across Network member organizations to standardize the inpatient rehab referral process. The guidelines include criteria to help referrers determine when a patient is a candidate for inpatient rehab, medically stable, rehab ready and appropriate for ALC designation. They also establish benchmarks for the timing of rehab referrals relative to ALC designation (before ALC designation), the number of rehab referrals to be submitted (minimum 2), and the timing of responses to referrals (within 2 business days). Finally, the guidelines also delineate the response categories rehab hospitals are to use to respond to rehab referrals.

The results of the ALC survey, as presented below, indicate that the rehab referral benchmarks are not being met.

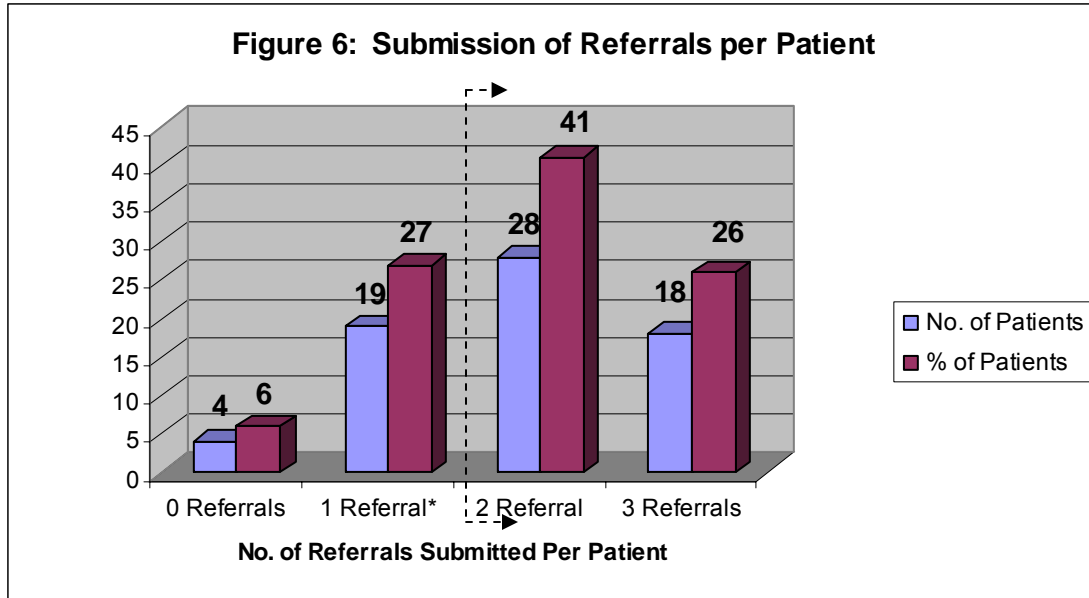
<sup>5</sup> Referral inefficiencies include delays in the submission of referrals relative to ALC designation; an insufficient number of referrals submitted; and delays in response to referrals as compared to the benchmarks established in the GTA Rehab Network's *Inpatient Rehab Referral Guidelines*. Further information regarding referral inefficiencies is provided later in this report.

**Timing of Referrals:** Forty-two percent of referrals were submitted *after* ALC designation; of these 28% were sent three or more days after ALC designation with 12% being sent more than 10 days after ALC designation (Figure 5). Of note, 4 referrals were sent more than 18 days (up to 25 days) post ALC designation. The extent to which these lengthier delays are strictly the result of breakdowns in referral processes or whether the delays were due to premature or inappropriate ALC designation is not known.



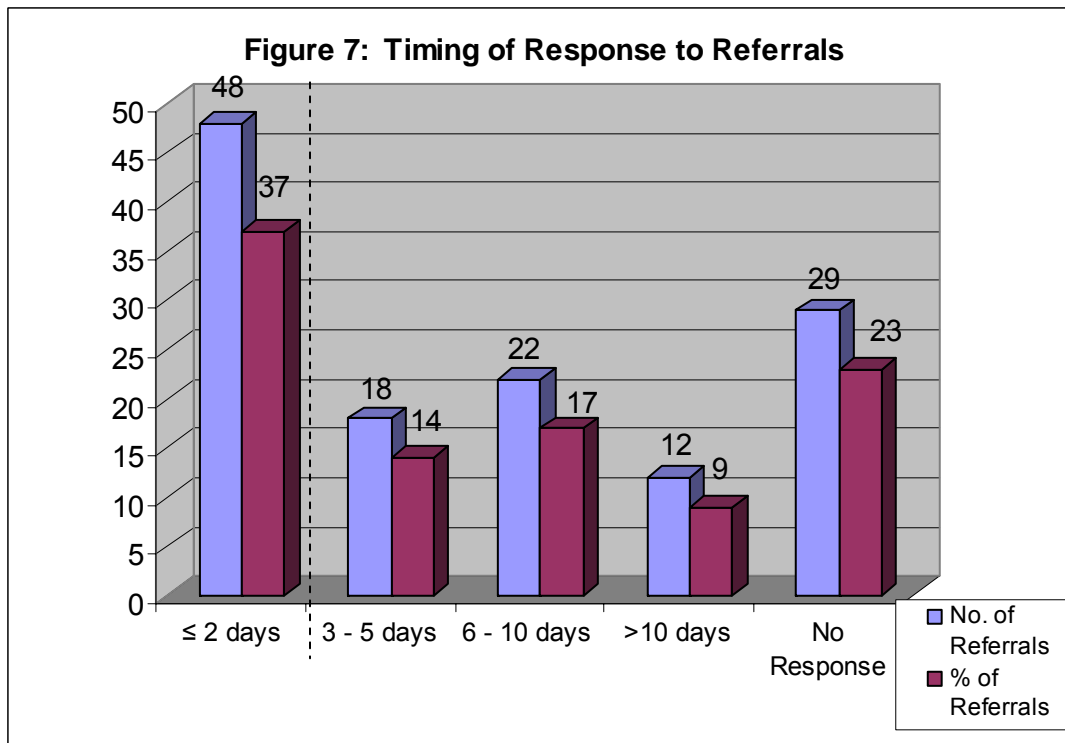
(Dashed line indicates Inpatient Rehab Referral Guideline benchmark)

**Number of Referrals Submitted:** The benchmark for the number of referrals to be submitted (minimum 2) was not achieved for 33% of the patients waiting for rehab in ALC. Of these, 6% had *no* rehab referral submitted and 27% had only one rehab referral submitted. (Figure 6)



(Dashed line indicates Inpatient Rehab Referral Guideline benchmark)

Timing of Response to Referrals: For 62% of referrals, the response to the rehab referral was not given within the 2-business day benchmark. No response was given for 22% of these referrals. For 31% of these referrals, the response was given 3-10 days after the referral was sent. For 9% of these referrals, the response was given more than 10 days after the referral was sent (Figure 7).



(Dashed line indicates Inpatient Rehab Referral Guideline benchmark)

### 3.5 Geriatric Rehab

As patients waiting for geriatric rehab comprise the largest rehab population group waiting in ALC for rehab with the longest total ALC days (365 days), a separate analysis of the survey results specific to geriatric rehab referrals was conducted. In addition to identifying patient characteristics, the analysis was also done to determine the degree to which referral inefficiencies and bed capacity contributed to length of stay in ALC.

Patient Profile: There were 30 patients waiting in ALC for geriatric rehab. These patients had a variety of diagnoses (e.g., orthopaedic and respiratory) and multiple medical issues/complexity (e.g., failure to cope). Twenty-three percent (N=7) of the patients waiting for geriatric rehab had a primary orthopaedic diagnosis. Of these, 5 patients were awaiting rehab following a hip fracture. Other types of diagnoses included: acute renal failure, pneumonia, hypertension, pulmonary embolism, fall and sprained ankle, fibromyalgia, arterial leg ulcer, dehydration/failure to cope, falls, GI upset or bleed, and low back pain. Thirty-seven percent of these patients had one or more special medical needs, the most frequently cited of which was incontinence.

Referral Patterns and Processes: Fifty-three referrals were submitted on behalf of 30 patients awaiting geriatric rehab. Referrals were submitted to rehab centres and hospitals that have either specialized geriatric rehab programs or general rehab programs that accept geriatric patients, or low tolerance long duration geriatric rehab in complex continuing care (CCC).

Referral inefficiencies were present for 94% of patients awaiting geriatric rehab. The greatest inefficiencies were seen in response to referrals. For 74% (39) referrals, the benchmark to respond within 2 business days was not achieved. The findings also indicate that there is room for improvement on the acute care end of the referral process as well. Benchmarks for timing and number of referrals submitted were not achieved for approximately 40% of referrals.

Bed Capacity: According to the survey findings, the average ALC length of stay for patients referred for geriatric rehab was 17 days. There were 6 patients who were not discharged during the survey period and of these, 5 patients had a length of stay in ALC of 20 or more days.

To determine the extent to which capacity to accommodate patients in rehab may be contributing to length of stay in ALC, the ratio of patients referred for geriatric rehab was compared to the ratio of designated rehab beds that can accommodate geriatric rehab patients.<sup>6</sup> It is acknowledged that there are limitations to this approach; however, the analysis draws on information that is currently available in an effort to examine this issue more closely.

The ALC survey results found that the ratio of patients waiting in ALC for geriatric rehab relative to the total number of patients waiting for rehab in ALC was 4:10. Recognizing that there are various rehab programs that can accommodate geriatric rehab patients, if we first look only at those rehab programs that specialize in geriatric rehab, the ratio of designated beds for geriatric rehab (94)<sup>7</sup> relative to the total

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<sup>6</sup> The analysis was restricted to the six freestanding adult rehab hospitals located in the Toronto Central LHIN and Central LHIN boundaries: Baycrest, Bridgepoint Health, Providence Healthcare, St. John's Rehab Hospital, Toronto Rehab and West Park Healthcare Centre. The results of the GTA Rehab Network 2003 ALC Survey found that 88% of ALC patients waiting for rehab were in the Toronto region hospitals. Rehab referrals from these acute care hospitals are typically directed to the freestanding rehab hospitals. Designated rehab beds located in other Toronto region hospitals have not been included as they do not accept external referrals.

<sup>7</sup> These geriatric rehab beds are located at Baycrest, Providence Healthcare and Toronto Rehab. Beds designated for Geriatric Assessment and Treatment have not been included.

number of designated rehab beds (737)<sup>8</sup> is approximately 1:10. If the analysis is expanded to include the additional general rehab and CCC beds available in the freestanding rehab hospitals that accept geriatric patients (83)<sup>9</sup>, the ratio increases to 2:10. However, in comparing the ratio of patients waiting in ALC for geriatric rehab (4:10) to the ratio of geriatric rehab beds including specialized/general/CCC beds (2:10), the data suggest a gap in capacity.

The potential influence of capacity on length of stay in ALC may also be inferred from information about how long it takes for patients to be transferred to rehab once the rehab referral is accepted. The ALC survey results indicate that the average time from acceptance to transfer was 7 days (Median = 5 days; Range = 1-23 days). With occupancy rates in geriatric rehab that typically range between 95 – 98%, this data also suggests that capacity in rehab contributes to ALC days.

Although the above statements are compelling, there are other considerations that must also be taken into account in any discussion about bed capacity. The capacity to accept a patient into an inpatient bed does not simply rely on bed vacancy. Admission to rehab is also determined by such factors as staffing and nursing ratios, the availability of equipment, the needs of other patients on the unit, the availability of physicians to admit patients and infection control issues to name a few.

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<sup>8</sup> Data is based on the number of adult rehab beds in the 6 freestanding adult rehab hospitals as per current information available in *Rehab Finder* and the GTA Rehab Network bed status report for 2006.

<sup>9</sup> In addition to the specialized geriatric rehab programs noted above, Bridgepoint Health has 16 rehab beds that serve adults who are “medically complex,” i.e. patients with cardiac, respiratory, oncology, transplants, GI problems, etc. in need of post-operative convalescence and rehab. There are 26 beds in CCC at West Park Healthcare Centre and 20 beds in CCC at Bridgepoint Health for low tolerance, long duration (LTLD) geriatric rehab. Providence Healthcare has 21 beds in CCC for LTLD geriatric rehab as well. These figures are based on current information available in *Rehab Finder*.

## 4.0 NEXT STEPS

### 4.1 Targeted Solutions to Reduce ALC Days

The ALC survey conducted in February 2006 provides qualitative and quantitative information about patients waiting for inpatient rehabilitation in ALC. From the data analysis, key areas have been identified and targeted solutions have been developed to reduce ALC days for patients waiting for inpatient rehabilitation in acute care.

#### i) Referral Inefficiencies

The ALC data indicate that referral inefficiencies (i.e., timing of referrals, the number of referrals submitted and response to referrals) contribute considerably to length of stay in ALC. For each of these indicators, benchmarks established in the Network's *Inpatient Rehab Referral Guidelines* are not being met. The identification of factors that contribute to ALC days (e.g., referral inefficiencies, management of special needs) points to the need for ongoing monitoring of patient access and flow from acute care to inpatient rehabilitation through an integrated approach.

**Targeted Solution:** To further enhance the efficiency of patient movement from acute care to rehab, the Network is moving forward with the development of a common rehab referral form building on the work from previous Network initiatives.

In addition to distribution of the overall findings of the ALC survey, an organization-specific analysis of the data was conducted for each of the participating acute care hospitals and the freestanding rehab centres to whom referrals were directed. All Network members are encouraged to use the findings of the survey to review their organizational processes for ALC designation, rehab referral submissions and response processes to achieve benchmarks established in the Network's *Inpatient Rehab Referral Guidelines*. The data collection tool used in the survey has been included in the Appendix section (Appendix C) and may be modified as needed to assist organizations with their own review process.

The GTA Rehab Network will convene a new standing committee, the Patient Access and Flow Committee, comprised of front-line referrers and receivers to monitor and identify operational system issues affecting patient transfers from acute care to inpatient rehab. The committee structure will provide the opportunity for representatives from acute care, freestanding rehab hospitals and community organizations to identify common issues affecting patient transfers, develop collaborative solutions and share best practices to reduce ALC days.

#### ii) Geriatric Rehab

Patients waiting for geriatric rehab represented the largest rehab population group by far in ALC. Comprising 43% of patients in ALC, patients referred for geriatric rehab had the longest total number of ALC days (365). The analysis of the ALC survey findings showed that these patients span multiple rehab diagnostic categories and can be medically complex. Referrers indicate they often have difficulty determining where to refer these patients and may not be accessing all available rehab options (e.g., geriatric rehab programs, other rehab programs that accept geriatric patients and Low Tolerance Long Duration rehab programs in complex continuing care). The data also indicated that referral inefficiencies were present for almost all of these patients. The capacity of the rehabilitation system to accommodate geriatric rehab patients may also be a contributing factor to length of stay in ALC for these patients.

**Targeted Solution:** Following the analysis of the ALC survey results, the GTA Rehab Network conducted key informant interviews to identify the resource needs of geriatric patients and issues

affecting access to geriatric rehab. As a result of these discussions and findings of the ALC survey, the Network, with the assistance of a contracted consultant, is working in partnership with the Regional Geriatric Program of Toronto and other content experts to explore barriers to geriatric rehab and increase clarity about where to refer geriatric patients for rehab, including those deemed “medically complex.” Through this initiative, clear definitions and criteria for terms including “geriatric,” “frail” and “medically complex” and the key components of rehabilitation required for these patients will be defined. A model for centralizing the geriatric rehab referral process, while supporting existing organizational relationships, will be explored. This initiative will include rehab programs provided across members of the GTA Rehab Network.

This initiative is part of the broader work that is being done concurrently by the Rehab Definitions Advisory Committee to develop common definitions that incorporate evidence-based parameters for other rehab programs. Standardization of programming will enhance our understanding of differences across programs, promote consistency and equitable access to rehab services and ensure a standard of care in rehab services.

### iii) Special Needs

The ALC survey found that 42% of patients had one or more special medical need. The most frequently cited special need was wound care. The extent to which wound care presented a barrier to timely transfer to inpatient rehab could not be determined from the data.

**Targeted Solution:** The GTA Rehab Network has conducted key informant interviews to increase the understanding of wound care management in rehab hospitals and to identify potential areas of partnership between acute care and rehab hospitals to facilitate transfer to inpatient rehabilitation. A number of factors are taken into account for rehab providers to manage patients with wounds:

- Operational costs associated with supplies and equipment rental
- Demand on nursing workload is dependent on the severity and number of wounds
- Infection control issues (e.g. MRSA/VRE status of patients referred and already admitted may delay transfer of patients with wounds)

The capacity to accommodate wound care needs at any one time cannot be determined because it is dependent on fluctuations in these factors. Strategies to support the transfer of patients with wound care needs to inpatient rehab have been suggested. For example, some organizations suggest cost-sharing of supplies and equipment to reduce the financial burden placed on rehab hospitals. Stakeholders also suggested that because dressings for wounds are individually sized and cannot be pre-stocked on the rehab unit, delays in transfers could be avoided if acute care transferred the patient with a few days supply of dressings. Improved communication regarding wound care management is also needed.

Comprehensive and current write-ups describing the number and severity of wounds, types of dressings needed and treatment plan recommended would help to expedite the transfer of patients to inpatient rehab units. Continued efforts to minimize the development of wounds in acute care are also encouraged. Implementation of these and other strategies will be explored further with the Patient Access and Flow Committee.

## **5.0 CONCLUSION**

The GTA Rehab Network is committed to working with its acute care and rehab partners to implement a systems-wide approach to improve patient flow through the system. As part of its strategic focus to improve service delivery and access, the ALC survey conducted in February 2006 provides detailed information about patients who are waiting for inpatient rehabilitation in acute care and the system issues contributing to their length of stay in ALC. The information that has been gleaned from the data analysis has been used to identify targeted solutions that together will contribute to smooth and efficient patient transitions from acute care to rehab. The ALC Task Group will continue to oversee the implementation of Network initiatives and achievement of deliverables to reduce ALC pressures and support timely access to inpatient rehabilitation.

## 6.0 APPENDICES

### APPENDIX A: GTA REHAB NETWORK ACTIVITIES TO REDUCE ALC DAYS

#### ***Previous Activities***

ALC Snapshots (2003): Conducted five ALC snapshots of patients awaiting rehab in ALC across the GTA. Analysis of findings summarized in 2004 report. Provided overall and organization-specific analysis of data.

Rehab Finder (2004): Launched web-based resource with admission information on inpatient and outpatient rehab programs/services to optimize matching of rehab patients to appropriate programs.

MSK Referral Form (2004-2005): Developed and implemented common rehab referral form to streamline the referral process for MSK referrals

Inpatient Rehab Referral Guidelines (2004-2005): Developed and implemented guidelines to standardize the rehab referral process.

Collaboration with Total Joint Network (2005): Development of new model of care for patients following total joint replacement to reduce length of stay in acute care.

www.myJointReplacement.ca (2005): Launched patient education website to assist patients and families in preparing for timely discharge from acute care following joint replacement.

#### ***Current Activities (2006)***

ALC Survey 2006: Conducted ALC survey and obtained detailed information on the types of patients in ALC, their medical complexity and total length of stay in ALC. Provided overall and organization-specific analysis.

E-Stroke Rehab Referral: Implementation and expansion of the e-Stroke Rehab Referral System to improve coordination and integration of inpatient, outpatient and home-based stroke rehab services in Toronto.

Wound Care: Conducted key informant interviews to increase understanding of wound care management in rehab hospitals and identify potential areas of partnership between acute care and rehab to facilitate timely transfer of patients to rehab.

Geriatric Rehab: Conducted key informant interviews to identify resource needs of geriatric patients and issues affecting access to geriatric rehab.

Rehab Definitions: Developing common definitions that incorporate evidence-based parameters for geriatric/other rehab programs. Standardization of programming will enhance understanding of differences across programs, promote consistency and equitable access to rehab services and ensures a standard of care in rehab services.

Medically Complex/Geriatric Rehab: Exploring barriers to, and increasing clarity around, rehab programs for geriatric and medically complex rehab candidates through development of clear definitions and admission criteria.

E-Referral: Submitted a proposal for funding of a common electronic rehab referral system for inpatient, outpatient and home-based rehab referrals. In the absence of funding, a common rehab referral form with population-specific inserts will be developed.

Stroke Rehab: Exploring the feasibility of an alternate program model for survivors of severe stroke to reduce wait time in ALC, length of stay in rehab and optimize patient outcomes.

Rehab for Hip Fracture Patients: Collaboration with the Total Joint Network on funding proposal and implementation of new framework of care for patients with hip fracture to reduce length of stay in ALC.

**APPENDIX B: GTA REHAB NETWORK ALC TASK GROUP MEMBERS**

Malcolm Moffat	President and CEO, St. John's Rehab Hospital ( <i>Chair</i> )
Dr. Bob Howard	Executive Vice President of Clinical Programs and Chief Medical Officer, St. Michael's Hospital
Jeanne Jabanoski	Executive Director, Integrated Medical Programs, University Health Network
Dr. Barbara Liu	Program Director, Regional Geriatric Program of Toronto
Anne-Marie Malek	President and CEO, West Park Healthcare Centre
Mary Beth Montcalm	President and CEO, Providence Healthcare
Mary Murphy	Toronto Central West Emergency Strategy Committee Coordinator/St. Michael's Hospital
Jim O'Neill	Acting Vice-President, St. Michael's Hospital
Mark Rochon	President and CEO, Toronto Rehab
Georgina Veldhorst	Vice President, Patient & Family Care and Chief Nursing Executive, North York General Hospital
Marian Walsh	President and CEO, Bridgepoint Health
Charissa Levy	Executive Director, GTA Rehab Network
Sue Balogh	Project Coordinator/Planner, GTA Rehab Network

**APPENDIX C: ALC DATA COLLECTION TOOL**

**Snapshot Period: February 6 – 22, 2006**

**For questions, please contact:  
S. Balogh, Project Coordinator/Planner**  
416-597-3422 Ext. 3923  
balogh.sue@torontorehab.on.ca  
FAX: 416-597-7021

Please provide the following information for each patient who is ready for transfer and awaiting rehabilitation in Alternate Level of Care during the snapshot period.

Hospital	
Submitted by	<b>Name:</b> _____ <b>Telephone:</b> _____
Primary Diagnosis of Patient	
Age	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Please indicate Diagnostic <u>Rehab</u> Group	<input type="checkbox"/> ABI <input type="checkbox"/> Amputee <input type="checkbox"/> Burns <input type="checkbox"/> Cardiac <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Geriatric <input type="checkbox"/> MSK <input type="checkbox"/> Neurology <input type="checkbox"/> Oncology <input type="checkbox"/> Respiratory <input type="checkbox"/> Spinal Cord <input type="checkbox"/> Stroke <input type="checkbox"/> Trauma <input type="checkbox"/> Other_____
Does patient require pre-rehab (e.g. strengthening, improved weight-bearing status)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate the Complex/Special Needs of Patient (please check all that apply)	<input type="checkbox"/> IV Peripheral <input type="checkbox"/> IV PICC <input type="checkbox"/> IV Other <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Continuous O2 <input type="checkbox"/> Intermittent O2 <input type="checkbox"/> NG tube <input type="checkbox"/> GJ tube <input type="checkbox"/> TPN <input type="checkbox"/> Active Psychiatric Issues <input type="checkbox"/> Wandering <input type="checkbox"/> Behavioural Issues <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Ostomy <input type="checkbox"/> Ventilator <input type="checkbox"/> Wound Care <input type="checkbox"/> VRE/MRSA <input type="checkbox"/> CPM <input type="checkbox"/> NWB <input type="checkbox"/> Pressure Beds <input type="checkbox"/> Immuno-Def. Drugs <input type="checkbox"/> Incontinence <input type="checkbox"/> Restraint/Supervision Housing: <input type="checkbox"/> Homeless <input type="checkbox"/> May require LTC post rehab Social Support: <input type="checkbox"/> No social support <input type="checkbox"/> Limited social support
Level of orientation	<input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time
Is patient able to follow commands/instructions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date Patient was designated as ALC (yyyy/mm/dd)	
Has referral been made to rehab?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If referral has been made, please indicate the level of intensity and type of rehab referred to:	<input type="checkbox"/> Regular <input type="checkbox"/> Low Tolerance Long Duration/Slow stream <input type="checkbox"/> ABI <input type="checkbox"/> Amputee <input type="checkbox"/> Burns <input type="checkbox"/> Cardiac <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Geriatric <input type="checkbox"/> MSK <input type="checkbox"/> Neurology <input type="checkbox"/> Oncology <input type="checkbox"/> Respiratory <input type="checkbox"/> Spinal Cord <input type="checkbox"/> Stroke <input type="checkbox"/> Trauma <input type="checkbox"/> Other_____

ALC Survey 2006: Mapping the way to targeted solutions

Please provide the following information for each rehab referral submitted:		
Referral 1	Referral 2	Referral 3
<p>Organization:</p> <p>Date of Referral: (yyyy/mm/dd)</p> <p>Date of Response to Referral: (yyyy/mm/dd)</p> <p>Response to Referral:</p> <p><input type="checkbox"/> Referral is declined: (specify)</p> <p><input type="checkbox"/> Decision is pending:</p> <p><input type="checkbox"/> referral form is incomplete</p> <p><input type="checkbox"/> patient status precludes decision</p> <p><input type="checkbox"/> Referral is accepted</p> <p><input type="checkbox"/> Referral is accepted and waitlisted</p> <p><input type="checkbox"/> No Response</p> <p>Please indicate if:</p> <p><input type="checkbox"/> Patient refused bed offer</p>	<p>Organization:</p> <p>Date of Referral: (yyyy/mm/dd)</p> <p>Date of Response to Referral: (yyyy/mm/dd)</p> <p>Response to Referral:</p> <p><input type="checkbox"/> Referral is declined: (specify)</p> <p><input type="checkbox"/> Decision is pending:</p> <p><input type="checkbox"/> referral form is incomplete</p> <p><input type="checkbox"/> patient status precludes decision</p> <p><input type="checkbox"/> Referral is accepted</p> <p><input type="checkbox"/> Referral is accepted and waitlisted</p> <p><input type="checkbox"/> No Response</p> <p>Please indicate if:</p> <p><input type="checkbox"/> Patient refused bed offer</p>	<p>Organization:</p> <p>Date of Referral: (yyyy/mm/dd)</p> <p>Date of Response to Referral: (yyyy/mm/dd)</p> <p>Response to Referral:</p> <p><input type="checkbox"/> Referral is declined: (specify)</p> <p><input type="checkbox"/> Decision is pending:</p> <p><input type="checkbox"/> referral form is incomplete</p> <p><input type="checkbox"/> patient status precludes decision</p> <p><input type="checkbox"/> Referral is accepted</p> <p><input type="checkbox"/> Referral is accepted and waitlisted</p> <p><input type="checkbox"/> No Response</p> <p>Please indicate if:</p> <p><input type="checkbox"/> Patient refused bed offer</p>
Was a 2 <sup>nd</sup> referral required due to change in client status while ALC?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Discharge	Has patient been discharged? <input type="checkbox"/> Yes      Date of Discharge: _____ (yyyy/mm/dd) <input type="checkbox"/> No	
Discharge Diagnosis		
Actual Discharge Destination	REHAB: <input type="checkbox"/> Regular Rehab <input type="checkbox"/> LTLD/slowstream rehab HOME: <input type="checkbox"/> Home <input type="checkbox"/> Home with support OTHER (Please specify): _____	
Total No. of Days Patient Designated ALC Awaiting Rehab		

## APPENDIX D: INPATIENT REHAB REFERRAL GUIDELINES (2005)

### INTRODUCTION

The *Inpatient Rehab Referral Guidelines* are intended for general application across multiple rehab populations in need of **regular** or **low tolerance long duration** (i.e. slow stream) inpatient rehabilitation.

To optimize the rehab referral process, these guidelines are organized around patient-specific criteria related to the determination of patients suitable for rehab, their medical stability and readiness for rehab.

The benefits of these guidelines are:

- to ensure that rehab referrals are submitted in a timely and appropriate manner
- to minimize the number of days that patients are waiting in Alternate Level of Care (ALC).

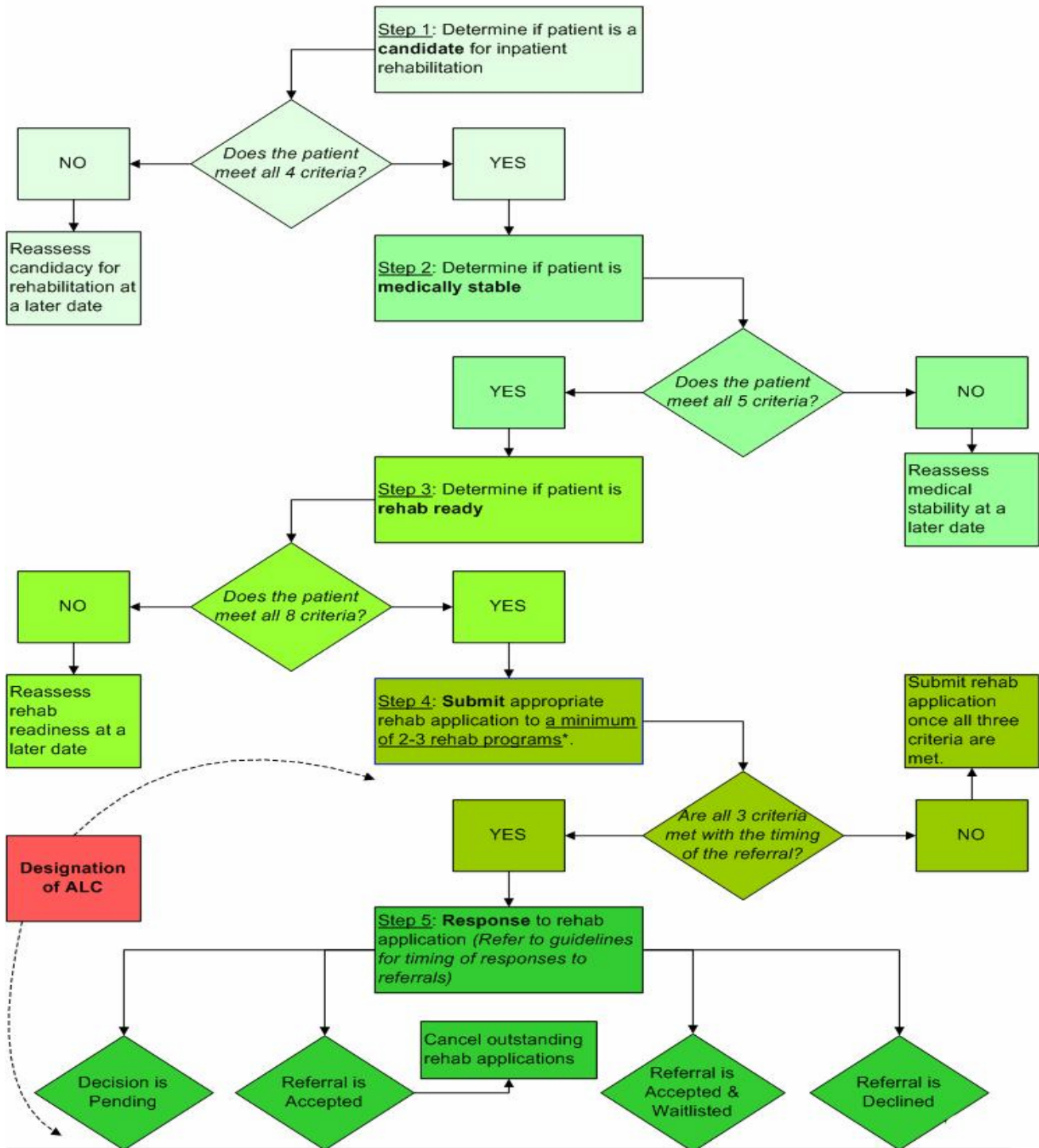
Application of **each and every component** of these guidelines should result in the submission of rehab referrals **before** a designation of ALC is made.

(Further information regarding ALC designation can be found in the Appendix.)

Recognizing that each rehab program has its own set of admission criteria, **these guidelines are to be considered in their entirety and used in conjunction with the specified admission criteria of individual inpatient rehabilitation programs.**

Detailed information about the admission criteria of individual rehab programs can be found using the admission information tool, *Rehab Finder*, available on the GTA Rehab Network website (see: [www.gtarehabnetwork.ca](http://www.gtarehabnetwork.ca)).

**Inpatient Rehab Referral Guidelines - Quick Reference Guide**



\*Submission of the rehab application to a minimum of 2-3 rehab programs may not be required in hospitals with internal rehab beds.

**INPATIENT REHAB REFERRAL GUIDELINES**

**Determining if a patient is a candidate for inpatient rehabilitation ...**

- ✓ Patient demonstrates by documented progress the potential to return to pre-morbid/baseline functioning or to increase in functional level with participation in rehab program.
- ✓ There is reason to believe that, based on clinical expertise and evidence in the literature, the patient's condition is likely to benefit from the rehab program/service.
- ✓ Goals for rehabilitation have been established and are specific, measurable, realistic and timely.
- ✓ The patient or substitute decision-maker has consented to treatment in the program and demonstrates willingness and motivation to participate in rehab program. (Exception: patients with reduced motivation/initiation secondary to diagnosis e.g. brain injury, depression).

**Determining Medical Stability ...**

- ✓ A clear diagnosis and co-morbidities have been established.
- ✓ At the time of discharge from acute care, acute medical issues have been addressed; disease processes and/or impairments are not precluding participation in rehab program.
- ✓ Patient's vital signs are stable.
- ✓ No undetermined medical issues (e.g. excessive shortness of breath, falls, congestive heart failure).
- ✓ Medication needs have been determined.

**Determining Rehab Readiness ...**

- ✓ Patient meets the criteria of a rehab candidate as defined in guideline above.
- ✓ Patient meets the criteria of medical stability as defined in guideline above.
- ✓ All medical investigations have been completed or a follow-up plan is in place at time of referral and follow-up appointments made by time of discharge.
- ✓ Patient's special needs have been determined.
- ✓ Patient is able to meet the minimum tolerance level of rehab program as defined by the admission criteria of rehab program.
- ✓ There are no behavioural or active psychiatric issues limiting patient's ability to participate in rehab program.
- ✓ Treatment for other co-morbid illnesses/conditions does not interfere with patient's ability to participate in rehab (e.g. dialysis or active cancer treatment resulting in fatigue or frequent absences from unit during rehab treatment sessions).
- ✓ Patient's discharge options following rehab have been discussed.

**Determining Timing of Submission of Application for Rehab ...**

- ✓ Patient meets the criteria of a rehab candidate as defined in the guideline above.
- ✓ Patient meets the criteria of medical stability as defined in the guideline above or patient's date of medical stability can be identified within the next 1-2 days of submission of application.
- ✓ Patient meets the criteria for rehab readiness as defined in the guideline above or the date for rehab readiness can be identified.

**Note I:** Referrers should notify rehab facilities of the cancellation of the referral in the event that the referral is no longer required (e.g. patient is accepted elsewhere).

**Note II:** Timing of ALC designation is based on patient meeting the criteria for rehab candidacy, medical stability and rehab readiness.

### **Determining Number of Referrals to be Submitted ...**

- ✓ Organizations should send referrals to a minimum of 2-3 rehab programs as appropriate.<sup>10</sup>

Detailed information about the admission criteria of individual rehab programs can be found using the admission information tool, **Rehab Finder**, available on the GTA Rehab Network website (see: [www.gtarehabnetwork.ca](http://www.gtarehabnetwork.ca)).

This web-based resource provides a comprehensive listing of all publicly-funded and fee-for-service rehab programs/services provided by hospitals and access centres that are members of the GTA Rehab Network.

**Rehab Finder** allows you to search for rehab programs by:

- Patient Population (including age)
- Organization
- Service Setting
- Special Needs
- Geographical Region

Information on **Rehab Finder** includes:

- Description of the program
- Admission and Exclusion criteria
- Application process and forms
- Information about wait list management
- Contact details

### **Determining Timing of Responses to Referrals ...**

- ✓ Responses to referrals should be given within 2 business days of receipt of application.
- ✓ Responses to referrals should be specific to one of the following response categories:

- **Decision is pending** because:
  - i) referral form is incomplete
  - ii) patient's current status precludes a decision at this time
- **Referral is accepted.**  
(Provide date of admission)
- **Referral is accepted and waitlisted.**  
(Provide estimated date of admission). Reasons for waitlisting due to:
  - i) Current bed availability
  - ii) Current resource availability to accommodate complex patient needs
  - iii) Infection control issues
- **Referral is declined.**  
(Please be as specific as possible)

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<sup>10</sup> Please note that a minimum of 2-3 applications may not be required in hospitals with internal rehab beds.

### **Alternate Level of Care (ALC) Designation:**

The following information has been drawn from the Canadian Institute for Health Information's (CIHI) Discharge Abstract Database (DAD) Abstracting Manual.<sup>11</sup>

#### **An ALC patient:**

- ✓ has finished the acute care phase of his/her treatment but remains in the acute care bed
- ✓ no longer requires services that must be delivered in an acute care hospital setting
- ALC guidelines are only applicable to active treatment/acute care discharges
- ALC designation is not used for extended/chronic care, residential care, intermediate/personal care, or day care surgery cases
- ALC requires a medical decision to be made by the attending physician or authorized hospital designate to determine when the patient no longer requires acute care services
- ALC status is often identified through a collaborative interdisciplinary approach.

#### **ALC Codes:**

There are a number of Diagnosis (ICD-10-CA) codes that can be applied to ALC patients. Please refer to the CIHI Discharge Abstract Data Abstracting Manual for information regarding specific coding.

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<sup>11</sup> CIHI Discharge Abstract Data Abstracting Manual, Chapter 10:1 – 10, April 2003

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