

BEYOND ACUTE CARE: NEXT STEPS IN UNDERSTANDING ALC DAYS

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1.0 EXECUTIVE SUMMARY

In its continued efforts to improve the delivery of and access to rehabilitation services, the GTA Rehab Network has been at the forefront of identifying issues related to patients waiting for inpatient rehab in Alternate Level of Care (ALC) beds and implementing system-wide strategies to address the delays. This report provides a summary of the Network's work to date and a detailed account of its most recent ALC research findings. It also describes the next phase of exploration currently being undertaken by the Network.

Through its previous work, the Network identified the following trends in the ALC landscape for patients awaiting inpatient rehabilitation:

- Geriatric patients have comprised the largest ALC rehab population waiting for inpatient rehab, typically with the longest lengths of stay.
- Referral process inefficiencies have contributed to delays in the submission of and response to rehab referrals.
- Patients who require inpatient rehabilitation have had increasingly complex medical needs.
- Although bed occupancy rates in rehabilitation are high, further exploration of opportunities to improve bed utilization and reduce waitlists for rehabilitation is warranted.

However, the Network's latest research suggests the issue of ALC for rehab patients extends beyond the acute care phase of the continuum:

- Recent Network survey findings estimate that 4% of occupied rehab beds and 14.5% of beds in complex continuing care (CCC) used for Low Tolerance Long Duration rehab are occupied by patients who are waiting for an alternate level of care. Of these, the majority of patients are waiting for a long-term care bed. Delays in discharging patients *from* rehabilitation reduce the capacity of rehab to admit ALC rehab patients *into* rehab.
- There is no established definition of ALC for rehabilitation. In the absence of such a definition, the tracking of ALC in rehab is inconsistent or non-existent, thus limiting the system's capacity to measure the extent of the problem and identify appropriate strategies to improve the throughput of patients in rehab.

For each of these highlighted issues, the GTA Rehab Network has taken an active role in collecting detailed information to elucidate the contributing factors. It has also taken these findings and used them to develop and implement targeted solutions from a system-wide perspective to improve timely access to rehabilitation.

2.0 BACKGROUND

The GTA Rehab Network is comprised of 33 publicly-funded hospitals (acute care, community and rehab) and community-based organizations from across the Greater Toronto Area that are involved in the planning and provision of rehabilitation services. Since its inception, the Network has been a leader in improving the planning and delivery of rehab care and its strength is developing innovative solutions to system-wide issues. The Network's strategic priorities are to align with and influence Ontario's Health Transformation Agenda; improve service delivery and access; improve planning and performance measurement; and share best practices and enhance knowledge exchange. Through its membership, the GTA Rehab Network works towards its vision of an integrated rehabilitation system that meets the needs of rehabilitation patients through all parts of the healthcare continuum.

3.0 ALC IN ACUTE CARE FOR PATIENTS AWAITING INPATIENT REHAB

The GTA Rehab Network has collected detailed information about patients waiting in acute care for inpatient rehabilitation from its acute care and rehab hospital member organizations. At each point of data collection, the findings were used to identify opportunities for improvement and implement solutions to effect change. The data findings and targeted solutions are summarized below.

3.1 ALC Snapshots 2003

In 2003, the Network conducted five ALC snapshots of patients awaiting inpatient rehab in ALC across the GTA. Data findings from these surveys revealed that the issues related to ALC within the GTA were largely a Toronto region concern with the majority of ALC patients located in Toronto hospitals. The findings also identified inefficiencies in the referral system (e.g. inconsistencies in the timing of referrals relative to ALC designation, delays in response time to referrals) and pointed to the need for improvements in referral processes to optimize patient flow from acute care to inpatient rehabilitation.

A detailed summary of the findings can be found in the Network's report, *Analysis of Alternate Level of Care (ALC) Snapshots: Patients Awaiting Rehabilitation in ALC and Inpatient Rehabilitation Capacity, May 2004*.

Targeted Solutions:

In response to the 2003 findings, the GTA Rehab Network developed and implemented a number of resources to support the timely transfer of patients to inpatient rehabilitation. These included:

- ***Rehab Finder:*** The first, comprehensive web-based listing of information on inpatient and outpatient rehab programs. By using *Rehab Finder*, referrers can enter specific search criteria to locate the best rehab options for their patients.
- ***MSK Referral Form:*** A common rehab referral form to streamline the referral process for MSK referrals.
- ***Inpatient Rehab Referral Guidelines:*** Standardized rehab referral processes for use across the GTA. These guidelines established benchmarks for the timing of rehab referrals (before ALC designation), the number of rehab referrals to be submitted (minimum of two) and the timing of response to referrals (within two business days).

3.2 ALC Survey 2006

In the fall of 2005, the MOHLTC Transformation Agenda directed acute care hospitals to decrease ALC days. To help its members work towards this goal, the Network conducted another ALC survey to provide a detailed review of patients waiting for rehab in ALC. The survey was conducted in three acute care hospitals within the Toronto Central LHIN boundary from February 6–22, 2006. The survey was conducted over a two-and-a-half week period rather than as a one-day snapshot to enable the collection of information about length of stay in ALC. Detailed information about patient characteristics, special needs and the type and intensity of rehab needed was also collected. An additional function of the survey was to evaluate adherence to the benchmarks established by the Network's *Inpatient Rehab Referral Guidelines*.

Findings from the 2006 survey showed that the largest rehab population groups waiting in ALC as determined by primary rehab need were:

- Geriatric (43%) with the highest *total* ALC days (365 days)
- Stroke (16%); *total* ALC days (79 days)
- MSK (13%); *total* ALC days (61 days)

The survey revealed that 42% of patients in ALC had one or more special need with wound care cited most frequently. The survey also found that further improvements to achieve the benchmarks set out in the *Inpatient Rehab Referral Guidelines* were needed to reduce referral inefficiencies.

Targeted Solutions:

- ***Geriatric Rehab:*** Patients referred for geriatric rehab had the longest total length of stay in ALC. Referral inefficiencies were present for almost all patients referred. Stakeholder feedback to the Network indicates that referrers often have difficulty determining where to refer geriatric patients for rehab, which may account for some of the referral inefficiencies found. The Network, in partnership with the Regional Geriatric Program of Toronto and other content experts, have worked to increase clarity about where to refer geriatric patients for rehab, including those deemed “medically complex.” As a result of this work, the following were developed:
 - Clear definitions and criteria for terms including “geriatric,” “frail” and “medically complex.”¹
 - A *Geriatric Rehab Definitions Framework* defining the key components of geriatric rehabilitation required for these patients.²
 - A triage guideline for referrers to help determine the most appropriate rehab options for geriatric patients.
- ***Special Needs:*** The GTA Rehab Network conducted key informant interviews to increase its 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 included: 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 dressing supplies are ordered by rehab and received; and improving communication of treatment plans for wound care management. The development of the Network’s *Inpatient Rehab/CCC Referral Form* (see below) specifically addressed the gap in communication around wound care management by standardizing the collection of information required by rehab/CCC to plan for patients with wound care needs.
- ***Referral Inefficiencies:*** To minimize delays in the transfer of patients caused by referral inefficiencies, the overall findings of the ALC survey *and* organization-specific results were circulated to Network members. Members were encouraged to use the findings to review

¹ See the GTA Rehab Network report, *Clarifying the Complexities of Inpatient Geriatric Rehab, February 2007*.

² 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 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.

organizational processes for ALC designation, rehab referral submissions and response processes to achieve benchmarks established in the Network's *Inpatient Rehab Referral Guidelines*.

The Network also convened the Patient Access and Flow Committee, a standing committee comprised of front-line rehab referrers and receivers, to monitor and identify operational system issues affecting patient transfers from acute care to inpatient rehab. The committee structure provides the mechanism through which acute care and rehab hospitals can identify common issues affecting patient transfers, develop collaborative solutions and share best practices to reduce ALC days.

3.3 ALC Survey 2007

To further increase the understanding of ALC issues for rehab patients, the Network conducted an ALC survey in 2007 that included both acute care and rehab perspectives. The survey was conducted during the week of March 5–9, 2007 in Toronto-based acute care and rehab hospitals.

Key findings include the following:

- Similar to the 2006 survey findings, the largest rehab population group waiting in ALC was the Geriatric/Medical rehab population (25%), followed by MSK (23%) and Neuro (10%).
- The number of ALC patients with one or more special needs increased from 42% to 50%, with wound care again being the most frequently occurring special need.
- Length of stay in ALC was calculated for patients discharged during the survey period and the findings indicated that the patients referred for MSK rehab and Geriatric/Medical rehab had the longest length of stay in ALC (119 days and 73 days respectively). It should be noted that patients referred for rehab by General Internal Medicine units (typically geriatric patients) accounted for 50% of the total number of ALC days. These patients were generally medically complex with more special needs relative to the other ALC patients.
- The survey also found that improvements were seen in achieving referral process benchmarks, as set out in the Network's *Inpatient Rehab Referral Guidelines*, particularly around the timing of referral submission with 78% of referrals submitted either before or on the day of ALC designation.

The findings from the rehab perspective shed more light on the factors contributing to delays in the transfer of patients to inpatient rehab:

- Forty-three percent of the referrals received during the survey period were waitlisted due to capacity (i.e., bed availability); 16% of referrals were declined because the patient was not appropriate for the rehab intensity applied for (i.e., regular stream vs. low tolerance/slow stream), did not meet the admission criteria or the equipment needs could not be accommodated.
- Nine percent of referrals were given "pending" status and of these, almost half (45%) were because more referral information was needed.
- Rehab hospitals also provided an estimate of the number of patients occupying rehab beds while waiting for an alternate level of care. Findings indicated that these "ALC in rehab" patients accounted for approximately 5% of designated rehab beds and 7% of LTLTD beds in complex continuing care.

Targeted Solutions:

- ***Standard Inpatient Rehab/CCC Referral Form:*** To further enhance the efficiency of patient movement from acute care to rehab, the Network has developed and implemented a common inpatient referral form for referrals to inpatient rehabilitation and complex continuing care.

The new referral form has been developed to:

- Improve the coordination and efficiency in the referral process by providing the right referral information and reducing the workload for referrers who are referring to multiple programs at different organizations.
- Lay the groundwork to support an e-referral system, which will increase our capability to monitor system access indicators consistently across programs.
- Support the Toronto Central LHIN's integration priority to improve the transition from hospital to rehab services.

The GTA Rehab Network will be adapting the inpatient referral form for community providers in the near future.

- ***Focused investigation of rehab capacity and ALC in rehab:*** The review of the 2007 data indicated similar findings to the 2006 survey from the acute care perspective with respect to the types of patients waiting for rehab in ALC. However, rehab survey results indicated a need for a better understanding of the factors affecting the capacity of rehabilitation hospitals to admit and accommodate the patients waiting in acute care for inpatient rehab. To address this, a survey to explore these issues was developed in late fall 2007 and conducted in February 2008 as described below.

4.0 ALC IN REHAB SURVEY 2008

To address the need for a more focused investigation of rehab capacity, the GTA Rehab Network conducted a survey snapshot on February 5, 2008 among its member rehab hospitals and two of its Toronto-area community hospitals. The focus of the rehab survey was to determine occupancy in both designated rehab beds and beds used for Low Tolerance Long Duration (LTLTD) rehab in complex continuing care (CCC). The survey also captured information to quantify and describe the number of patients waiting in rehab/LTLTD for an alternate level of care and also to identify existing practices for tracking ALC in rehab.

In terms of bed occupancy, the survey results indicated high bed utilization with a 93% occupancy rate in both the designated rehab beds and LTLTD beds in CCC. In exploring the reasons for empty beds, the most frequently cited reasons for empty designated-rehab beds was “no appropriate referrals” and “infection control issues.” In LTLTD, the most frequently cited reason for empty LTLTD rehab beds was “infection control issues.”

According to the survey data, 4% of the total number of occupied rehab beds were occupied by patients waiting for an alternate level of care. Of these, the highest percentage of patients (59%) were waiting for long-term care (LTC). Of the occupied LTLTD rehab beds in CCC, 14.5% were occupied by patients waiting for an alternate level of care, the highest percentage of which (87%) were also waiting for LTC. These patients account for a high number of ALC days. The amount of time patients had been waiting for LTC ranged between 13–221 days for patients waiting in designated rehab beds and 8–250 days for those waiting in LTLTD beds.

It should be noted that in its survey of CCC beds, the GTA Rehab Network focused specifically on beds used for LTLD rehab. However, if one takes a broader look at the extent of ALC across all CCC beds, the impact on the throughput of patients across the system is even greater. First, there is a potential for underreporting of ALC in rehab as some organizations transfer patients from their rehab beds to their CCC beds to await transfer to an alternate level of care as a strategy to reduce ALC days. Second, patients waiting for an alternate level of care in CCC beds also place demands on long-term care. The most recent data (March 11, 2008 survey) obtained from the Shared Information Management System (SIMS), found that 187 CCC beds across the SIMS Rehab/CCC partner organizations³ are occupied by patients waiting for an alternate level of care. It is likely that the majority of these patients are waiting for long-term care. Although these figures include patients in LTLD rehab beds, it can be estimated that the LTLD portion accounts for less than 20% of the total number of CCC beds occupied by ALC patients.⁴ Given the wait times for LTC reported in the GTA Rehab Network survey, it is clear that patients waiting for LTC beds in either rehab or CCC beds are beginning to create bottlenecks at the end of the inpatient continuum, affecting the movement of patients into rehab and through the healthcare system.

Finally, in addition to delays caused by waits for long-term care, the Network's survey also found that other challenges involved in discharging patients from rehab/LTLD were related to the availability of family and community resources to support discharge and the lack of appropriate discharge options for patients with more complex needs (e.g. wheelchair accessibility; cognitive or behavioural issues).

The February 2008 survey was also used to gather information about current practices within rehab hospitals to track ALC. Our survey results indicated that only 56% of the hospitals surveyed had formal structures in place to track ALC, and among these hospital, there was no consistency in the processes used. Challenges in tracking ALC stem from the absence of: (1) an objective measurement of functional goal achievement to determine discharge readiness; and (2) a definition of ALC for rehab that can be applied consistently across rehab programs and organizations.

Targeted Solutions:

- ***Definition of ALC for Rehab:*** The GTA Rehab Network will work with its partners to develop a definition of ALC for rehabilitation. The development and implementation of an ALC definition will support the standardized tracking of ALC patients in rehab and improve our capacity to identify problems and focused solutions to improve patient flow through the healthcare system.
- ***Discharge Guidelines for Rehab:*** The absence of criteria to determine when patients are ready for discharge from inpatient rehab contributes to delays in discharge and difficulties in identifying patients as "ALC." The GTA Rehab Network, through its Patient Access and Flow Committee, will be developing discharge guidelines, including a discharge planning tool to outline key activities and timelines involved in determining discharge readiness.
- ***Further investigation of reasons for empty beds:*** The 2008 survey indicated that the primary factors contributing to empty beds in designated rehab beds and LTLD rehab beds were "no appropriate referrals" and "infection control issues." The GTA Rehab Network will delve further into the nature of these issues to obtain a clearer understanding of occupancy rates.

³ Bridgepoint Health, Providence Healthcare, St. John's Rehab Hospital, Toronto Rehabilitation Institute and West Park Healthcare Centre.

⁴ This figure is based on the GTA Rehab survey findings, which showed that 33 patients were waiting for ALC in LTLD beds in CCC in the SIMS rehab/CCC partner organizations. Assuming a slow turnover rate for patients in CCC, these patients represent approximately 18% of the 187 ALC CCC beds accounted for in the SIMS data.

5.0 CONCLUSION

It is clear from the information in this report that ALC in acute care for patients awaiting inpatient rehabilitation has been a pressing issue requiring attention. What is also becoming apparent is that ALC is an emerging issue in rehab and CCC hospitals as well. Through its initiatives, the GTA Rehab Network has been effective in collecting detailed information about the factors contributing to ALC from both perspectives and using the information to develop and implement solutions. The GTA Rehab Network surveys have provided a fuller understanding of the types of patients waiting in ALC for inpatient rehabilitation; the characteristics of these patients with respect to their special needs; and the length of stay of these patients on a per rehab population basis. It has developed and implemented strategies to reduce referral inefficiencies that contribute to ALC days and has used the surveys to measure improvements that have contributed to system change.

In its continued efforts to promote the smooth transition of rehab patients through the continuum, the GTA Rehab Network has most recently turned its attention to examining and addressing the issue of ALC from the rehab perspective. The 2008 ALC in Rehab survey found that, on the snapshot day, rehab hospitals demonstrated good occupancy rates. Considering length of stay and current environmental issues within hospitals that impact infection control, there appeared to be little room for improvement in bed utilization. Given that this is our first look at the numbers for ALC in rehab across the Network there is value in ongoing monitoring.

Although ALC in rehab beds is relatively low at this point, there are several considerations that warrant attention:

- There are indications that the current number of patients in ALC may reflect an underreporting due to the transfer of patients to CCC to wait for long-term care (where ALC numbers are quite high).
- The full extent of ALC in rehab is not fully understood as only 56% of hospitals have formal mechanisms in place to track ALC. Of these, inconsistencies in ALC tracking processes may further mask the true extent of ALC in rehab.
- A comparison of 2007 and 2008 data indicates that there may be upward trend in the number of ALC patients in LTLD who are waiting for long-term care (i.e., 7% versus 14.5%).

The GTA Rehab Network will continue to collaborate with its partners as it moves forward with developing a definition of ALC and discharge guidelines for rehab and will look for opportunities to align its activities in relation to ALC with other work that is currently underway through the Ontario Hospital Association, the Toronto-area LHINs, and Shared Information Management Services (SIMS). The implementation of these new resources will enable the measurement of ALC consistently across organizations and support more effective discharge planning. Doing so will help to reduce ALC days and improve patient flow across the system so that patients will have timely access to the rehab services they need.