

IMPACT OF A REHABILITATION PATIENT FLOW FACILITATOR IN THE ACUTE CARE SETTING



Editor’s Summary: In *Impact of a Rehabilitation Patient Flow Facilitator in the Acute Care Setting* a staff person with clinical background works between the acute care organization (University Health Network) and a rehabilitation and complex continuing care hospital (Toronto Rehab) to facilitate the flow of patients between the two settings. Using a combination of interpersonal skills, assessment tools, protocols, policies, and clinical insight, the facilitator helps both organizations discharge patients from acute care who are appropriate for either rehabilitation or complex continuing care. The results were seen across many different population groups, including musculoskeletal patients, stroke patients, and acquired brain injury patients. Depending on the population group, there was a decrease in Alternate Level of Care days (or days spent waiting in acute care after acute care treatment was completed) ranging from 9 to 20 days. This results in significant cost savings to the system and a better experience for the patient.

Contact:

Sherra Solway

solway.sherra@torontorehab.on.ca

Authors:

Toronto Rehab

- Boaro N - Advanced Practice Leader, Neuro Rehab Program
- Lenahan K - Executive Director Patient Care, Neuro, Geriatric & MSK Rehab Programs
- Solway S - Director, Patient Safety, Best Practice & Patient Care Projects
- Velji K – Vice-President Patient Care & CNE

University Health Network

- Jabanoski J – Vice President, UHN Integrated Medical Programs
- McCumber T – Clinical Director, Nephrology, Endocrine, Emergency Medicine & Flow
- Neary M.A – Clinical Director, Krembil Neuroscience Program and Allied Health – Toronto Western Hospital
- Ratansi, N. – Project Manager, SIMS
- Sabo K – Vice President and Toronto Western Lead

| | |
|------------------------|---|
| <p>Purpose:</p> | <ul style="list-style-type: none"> • High number of ALC patients and ALC days at UHN reflect bottlenecks in patient flow from UHN to post-acute care destinations; • Delays of ALC patients are felt upstream, resulting in increased wait times and transfer delays for patients admitted through the Emergency Department as well as turnaways of patients requiring specialty services such as |
|------------------------|---|

| | |
|-----------------------------------|---|
| | <p>Neurosurgery</p> <ul style="list-style-type: none"> • This initiative was designed to address the problem of patients staying in acute care beds beyond the end of their acute care treatment due to challenges in getting them to the next level of care; Specific objectives were to: <ul style="list-style-type: none"> - Educate UHN staff about Toronto Rehab programs and determination of rehab readiness; - Enhance the referral process from UHN to Toronto Rehab to facilitate an increase in patient transfers; - Facilitate the integration of a Patient Flow Facilitator (PFF) role into acute care unit patient care teams to assess ALC patients & match patients to services at ALC facilities where available |
| Context: | <ul style="list-style-type: none"> • UHN is a large tertiary/quaternary care centre comprised of three main hospitals in Toronto, Canada. • Toronto Rehab is Canada's largest academic hospital specializing in adult rehabilitation and complex continuing care. The organization has several sites and is composed of seven programs of clinical care including Cardiac Rehabilitation & Secondary Prevention, Musculoskeletal Rehabilitation, Spinal Cord Rehabilitation, Neuro Rehabilitation, Geriatric Rehabilitation, Complex Continuing Care and Long-Term Care. • UHN has significant challenges with ALC patients remaining in acute care beds for extended periods of time, including patients requiring rehabilitation. • Completion of referral information and lack of a rehabilitation person on site to assist to problem solve flow of complex patients was identified as a need by UHN • UHN and Toronto Rehab partnered to find ways to expedite transfers of rehabilitation patients from UHN's General Internal Medicine (GIM) and Krembil Neuroscience Programs (KNP) to post-acute care designations. • The PFF role was piloted over a one year period. The model involved a Toronto Rehab assessment team member being available for consultation on patients considered to be rehabilitation candidates on GIM and KNP. |
| Resources | Estimated minimum operating dollars/FTEs needed to replicate this initiative is ~ \$55,000/0.5FTE. |
| Source of Resource: | Funding for this initiative came from UHN. |
| Population Group: | <ul style="list-style-type: none"> • Acute Care GIM and Neuroscience • Patients appropriate for Rehabilitation & CCC (including palliative care) |
| Patient Flow Entry and End | In this initiative, the patient is starting in the Emergency Department, GIM or Neuroscience unit of acute care and is intended to transfer to rehabilitation or complex continuing care |

| | |
|-------------------------------------|---|
| Points: | |
| Description/ Approach: | <ul style="list-style-type: none"> • Clinical leaders and staff engaged in diagnosing and implementing patient flow solutions within the discharge planning process. This involved developing a high-level process map and documenting key activities throughout the patient journey, from admission to discharge. • The PFF role was piloted over a one year period. The model involved a Toronto Rehab assessment team member being available for consultation on patients considered to be rehabilitation candidates on GIM and KNP. • The PFF attended key rounds on each of the acute care units and was available on pager throughout the day. • The PFF assisted with assessing and reviewing patients identified as ALC by the UHN care team, or patients who were not yet ALC but may be appropriate for referral. |
| Tools and Tactics: | All patients declined for rehabilitation or CCC were reviewed by the PFF and if deemed appropriate, an informal appeal was made. |
| Measurement Approach: | Primary measures/indicator was average ALC days by type of rehabilitation program to which the patient was being transferred to at Toronto Rehab (e.g., Acquired Brain Injury, Stroke, Musculoskeletal, Spinal Cord, Low Tolerance Long Duration (LTLTD) Rehab, Palliative Care and CCC). Comparison was made from one year prior to implementation of the pilot to one year post implementation (i.e. May 2007 – May 2008). |
| Impact/ Evaluation: | <ul style="list-style-type: none"> • The PFF resulted in a marked decrease in average ALC days for patients going to Toronto Rehab's Acquired Brain Injury (reduction of 10.8 days on average) CCC (20 days), LTLTD (11.2 days), and musculoskeletal rehab programs (8.8 days); • There was also a marked decrease in median ALC days for patients going to complex continuing care (41 days) and musculoskeletal rehab (7 days) programs. |
| Observation/ Discussion: | <ul style="list-style-type: none"> • The PFF role had a significant positive impact in expediting transfers for sub-populations of rehabilitation patients for which UHN was challenged with long wait times for placement; • The impact of the PFF role was most felt where patients were complex with multiple co-morbidities and special needs; the PFF's ability to communicate with the team on site and assess patients contributed greatly to their timely and ultimate transfer to rehab • This initiative facilitated the identification of trends in patient populations by program and organizationally; an objective review of Toronto Rehab's admissions processes program by program and opportunities to problem solve related to admission challenges • Cross-institutional partnerships between acute care and rehabilitation such as PFFs can have a positive impact on improving patient flow between the two sectors. |

| | |
|---|--|
| Critical Success Factors/ Lessons: | The individual fulfilling the PFF role needs have strong interpersonal and communication skills, have a clinical background and be knowledgeable about acute care processes and rehabilitation and CCC programs. |
| Limiting Factors: | <ul style="list-style-type: none"> • Equipment, environmental and other resource barriers to enhancing patient flow (e.g. enhanced skilled nursing, increased access to costly technologies such as VAC® therapy, bariatric equipment, behavioural management resources for one to one therapeutic intervention); • Need increased capacity to admit five days a week or more in all programs (some only admit three days a week due to physician availability) • Limited access to long term care, supportive housing and CCAC services to address ALC in rehab/CCC. |