

**ALC Resource Matching & Referral
Provincial Reference Model**
Business Process and Data Elements

March 2010




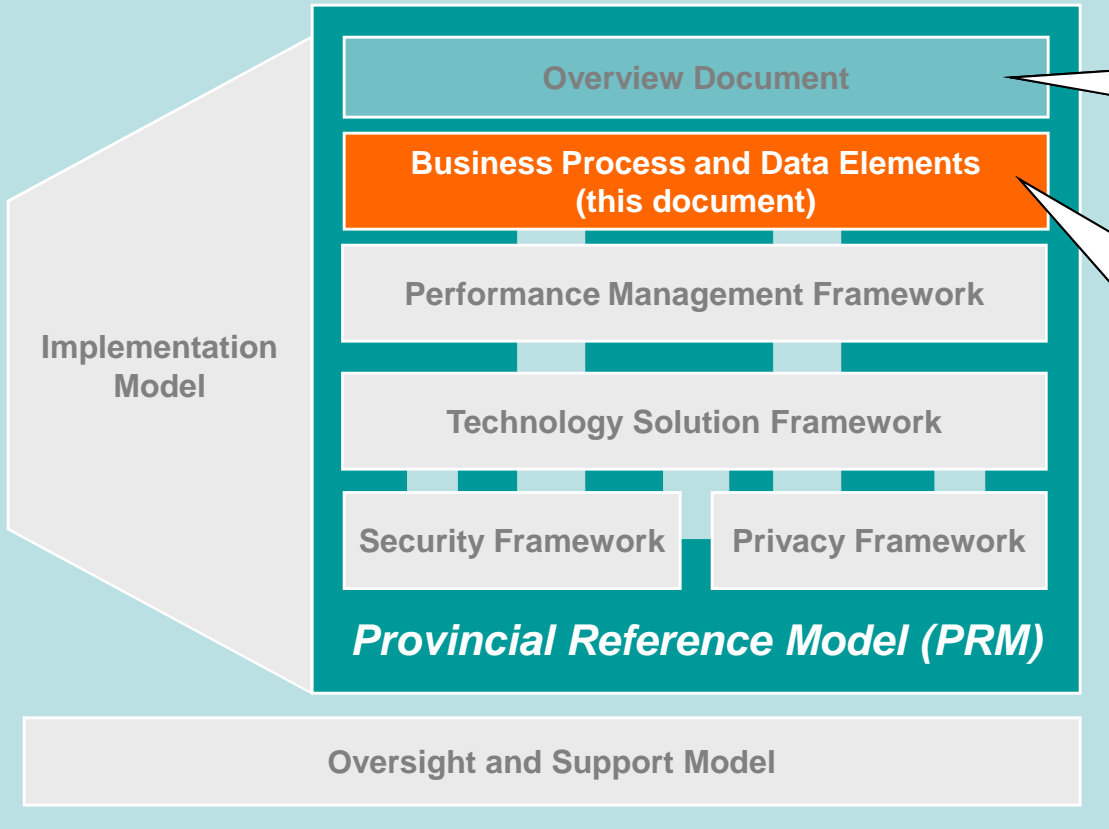
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Orientation to the Provincial Reference Model (PRM) Deliverables

All components of the PRM are integrated and interdependent. As a result, it is recommended that the reader of this document should review other components of the PRM to ensure a comprehensive understanding of the Business Process and Data Elements component.

Resource Matching and Referral Project Deliverables



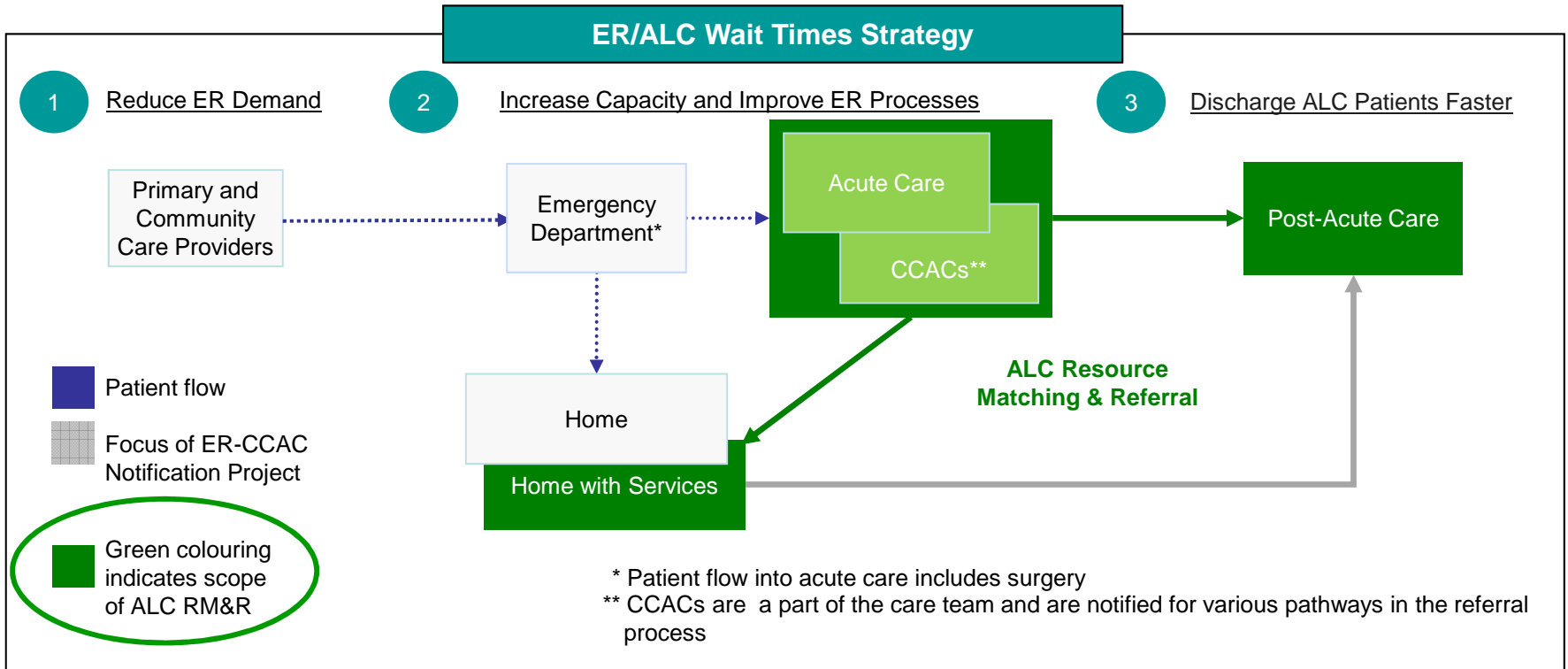
Review these documents:

The **Overview Document** provides a detailed overview of the PRM.

The **Business Process and Data Elements** document forms the basis for other component documents and serves as a key starting point and reference deck when reviewing PRM materials.

Project Scope

This project focuses on referrals from the acute to post-acute setting for four specific pathways* and will serve as the foundation for additional referral pathways in the future.



The ALC RM&R project consists of four in-scope post-acute care destinations:

- Acute to Rehab
- Acute to Long-Term Care (LTC)
- Acute to Complex Continuing Care (CCC)
- Acute to In-Home Services

RM&R Project - Guiding Principles

The following guiding principles have served as a foundation for the overall RM&R project.

RM&R Guiding Principles

General

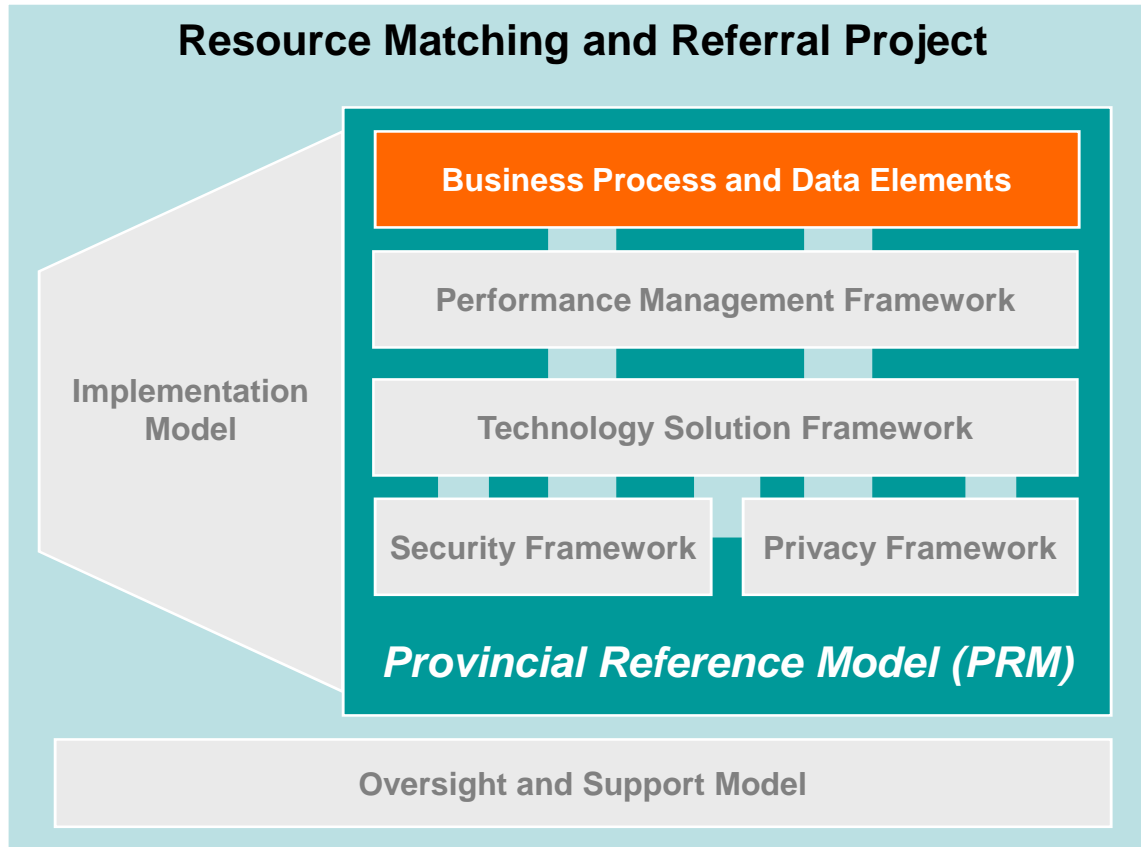
- The PRM will be outcomes-focused, identifying “what” needs to occur, and leave the “who” and “how” to LHINs/LHIN clusters.
- The PRM will not be tailored to a specific application, but will focus on the functionality required to support the future state of RM&R.
- The outcome of this initiative will be focused on reducing the ALC component of patients’ wait times and increasing patient throughput; however, the model will also be flexible to adapt to other types of referrals over time.

Implementation

- LHINs will be accountable for implementation results.
- LHINs/LHIN clusters will determine the most appropriate approach to implementation of RM&R solutions within their areas, including clustering and software selection.
- LHINs must be aligned to the PRM as they implement RM&R solutions.

Objectives

The RM&R PRM includes five distinct bodies of work*. This document details the main recommendations from the Business Process and Data Elements component.



The objectives of the Business Process and Data Elements work stream are:

- Provide detailed content expertise or knowledge on business requirements and guidelines and data elements
- Share information on the present state, identify potential implications for the reference model and where applicable, share information on existing implementations and lessons learned
- Identify issues, risks and barriers for the projects
- Inform the development deliverables
- Facilitate opportunities for information sharing and collaboration across organizations and sectors
- Contain significant geographic representation and significant representation of health service providers

***The PRM is supported by the Implementation Model to enable the LHINs to implement RM&R solutions and the internal Oversight and Support Model to support the ongoing RM&R project**

Context for Understanding Business Process and Data Elements

The Business Process and Data Elements deliverable forms the basis for the other work streams' deliverables and serves as a key starting point and reference document when reviewing PRM materials.

Context

- LHINs will need to align to the business processes, data elements and functional requirements outlined here as they implement RM & R solutions.
- The Business Process and Data Elements Sub-group used Care Management leading practices to define the high-level future state eReferral business processes.
- Functional requirement recommendations are a product of the Business Process and Data Elements sub-group work and are based on business needs in the referral process.
- The data elements support both the business process and performance indicators.
- The Ontario eReferral Specification will provide the basis to support interoperability of RM&R solutions between LHINs and LHIN clusters, such that as the state of RM&R matures over time, individual RM&R solution implementations can be linked to enable inter-LHIN referrals.
- **Next Steps**
 - Continue working with representative stakeholders to ensure that Care Management leading practice drives the business process and related activities

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Executive Summary

The ALC RM&R PRM includes high-level business processes and data elements that are based on leading practices for Care Management. These processes and elements will facilitate “the right care for the right patient at the right time” and achieve the objectives of reducing ALC days and increasing capacity in the acute care setting.

Key Findings

- Effective Care Management includes discharge planning early in the hospital admission and proactive assessments of the patient to determine needs and facilitate appropriate post-acute placement.
- Resource matching supports greater awareness of available post-acute resources to meet patient needs and preferences.
- Variations in referral processes lead to delays in referral initiation and response and inappropriate referrals.
- Adherence to key time frames in the referral process is required to facilitate efficient referral processing and patient movement.
- Common information exchange is needed to reduce ambiguity in referrals, increase efficiency in referral processing, standardize reporting and support system interoperability.

Key Considerations and Challenges

- Implementing standard high-level processes and data elements is needed to support communication between providers and expansion to other referral pathways.
- Standardization of processes and data elements will support adaptability of referral processes across the LHINs and individual providers.
- Systems integration across a vast number of disparate systems and re-use of data will increase data quality and reduce errors.

Executive Summary – Implications and Recommendations

Theme	Recommendation / Implication
Streamline Processes	<ul style="list-style-type: none"> ▪ Integrate systems to enable re-use of data and reduce manual processes ▪ Reduce redundant effort and become more efficient in the referral process, increasing productivity and freeing up resources to support patient care activities ▪ Increase information quality by re-using data to reduce the potential for error in data entry ▪ Electronic referrals will save time by sending multiple referrals electronically instead of manually faxing.
Process and Data Standardization	<ul style="list-style-type: none"> ▪ Implement standard high-level processes across the LHINs ▪ Implement common data and information to reduce ambiguity in the referral initiation and decision phases ▪ Implement clear transitions and key time frames for the referral process
ALC Determination and Referral Acceptance	<ul style="list-style-type: none"> ▪ Implement clear and standard evidence-based criteria for determining ALC ▪ Identify clear and standard criteria for admission to post-acute facilities ▪ Establishing clear acceptance criteria will help eliminate “cherry-picking” of patients. ▪ Tracking of referral denials and denial reasons
Facility and Service Information	<ul style="list-style-type: none"> ▪ Provide transparency into services available through resource matching against a catalogue of provider services ▪ Integrate patient choice into appropriate placement options to support patient placement satisfaction ▪ Communicate early notice of bed availability electronically to facilitate patient movement to post-acute providers

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Provincial ALC Definition

- On July 1, 2009, all acute and post-acute hospitals in Ontario began using a standardized **Provincial Alternate Level of Care (ALC) Definition** to designate patients ALC
- This definition was approved by the Ministry of Health and Long-Term Care (Ministry) in March 2009 and was developed in consultation with stakeholders from across the continuum of care, including:
 - Acute and post-acute hospitals (i.e. CCC, mental health and rehabilitation)
 - Community Care Access Centres (CCACs)
 - Ministry of Health and Long-Term Care (MOHLTC)
 - Local Health Integration Networks (LHINs)
 - Canadian Institute for Health Information (CIHI)
 - Ontario Hospital Association (OHA)
 - Ontario Health Quality Council (OHQC)
- The implementation of the ALC definition supports the goals of the provincial ER/ALC Information Strategy by capturing high-quality and near real-time data on all patients waiting in acute and post-acute hospitals for ALC.
- This information will help improve patient flow and reduce emergency room (ER) wait times and inform decisions about the allocation of resources.



Provincial Ontario ALC Definition

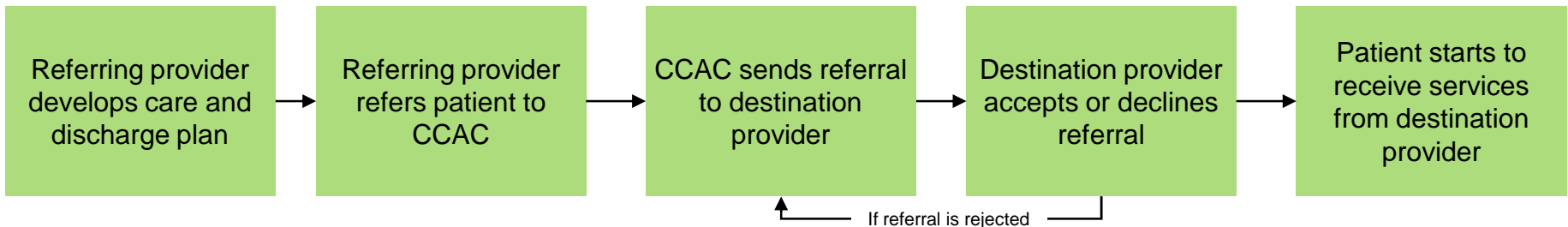
When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care (CCC), Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his delegate.

The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

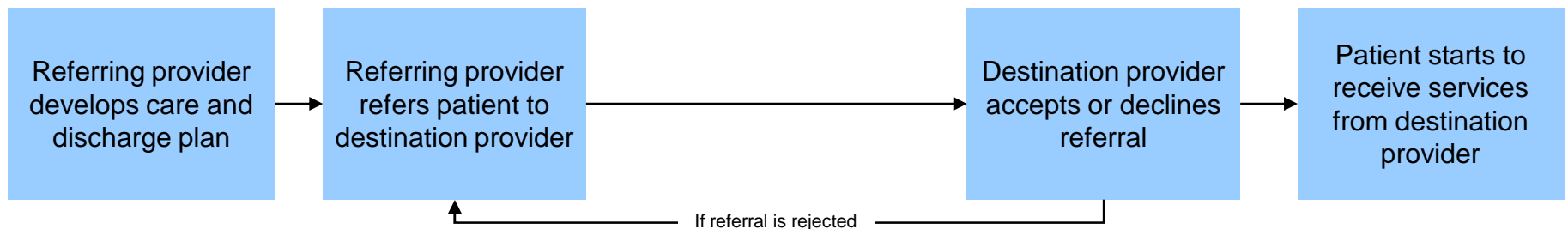
Current State Referral Pathways

There are currently two basic referral paths in Ontario that are utilized to support discharge planning and referrals to the discharge disposition from the referring provider to the destination provider.

1) Referrals that INVOLVE a CCAC



2) Referrals that DO NOT INVOLVE a CCAC



- Within these basic high-level processes, there can be a high degree of variation between LHINs, as well as within individual LHINs.
- The future state is defined for four distinct pathways – Acute to Rehab, Acute to Complex Continuing Care, Acute to Long-Term Care and Acute to In-Home Services.

Current Issues in the RM&R Business Process

Across these high-level processes, numerous issues in the current referral process have been identified, each lending insights into the future state of RM&R in the province.

Key Themes

Manual Processes

- Duplicate information input required
- Extensive use of paper, phone and fax
- Inconsistent information collected
- Limited implementation of system interfaces
- Status not centrally tracked

Process Standardization

- Inconsistent definitions, forms and systems
- Disparate Accountability
- Referral information requirements not uniform
- Criteria for admission unclear or not shared
- Target response times not widespread

ALC Determination and Referral Acceptance

- Patient information not consistently propagated
- Variations in discharge and admission criteria
- Limited availability of trained resources
- Limited hours of operation
- Multiple assessments of the same patient
- “Cherry-picking” of patients
- Limited capacity or opportunity to utilize community support services to avoid LTC placement

Facility and Service Information

- Limited awareness of destinations and availability
- Balance between patient choice and timely discharge
- Disconnect between discharge and admission criteria
- Notice of upcoming referrals not always shared

Implications for Future State

- Eliminate redundant work steps by streamlining processes and reusing data through improved interfacing and systems interoperability
- Reuse of data increases information quality by decreasing the chance of error in data entry
- Shared processes and standard definitions will increase efficiency in processing times for referrals
- Clear transitions, standard data elements and key time frames will support timely referral decision-making and patient transfers
- Minimum required data sets and standard ALC processes and level of care (LOC) criteria will reduce ambiguity in referral processing
- Predetermined criteria for matching resources to patient service needs reduces subjectivity in patient selection
- Transparency in provider services facilitates getting the right care for the patient
- Communication of bed and service availability assists in planning patient care and developing discharge options

Current Issues with Standardization

Most referral processes continue to be manual (i.e. phone and fax-based). Where RM&R solution implementations are underway, there is a standardization of processes, terminology and data elements within LHINs, but not across LHINs.

Key Themes

Data Elements and Terminology

- Most LHINs use manual referral processes with little standardization across or within LHINs
- Current RM&R implementation efforts have focused on standardization at LHIN level only
- eHealth Ontario is developing an eReferral specification

Messages

- Some early RM&R solutions utilized a messaging standard
- The Ontario eReferral specification will be based on the pan-Canadian standard

Ontario eHealth Blueprint Alignment

- Major eReferral components are not in place
- Provincial registries have not yet rolled out
- Provincial translation services are not in place

Implications for Future State

- Standardization of data and terminology enables entities to communicate within LHINs and across LHINs.
- Adoption of a messaging standard will enable:
 - Interoperability between solutions
 - Linkages to eventual Ontario eHealth Blueprint components
 - Referral reporting at a provincial level
- Design for use of Ontario eHealth Blueprint components as they become available

High-Level Design Guiding Principles

Focus:

Move toward standardization of business and clinical processes between acute and post-acute service providers to **increase capacity** in the acute setting by **discharging ALC patients more quickly and effectively**. The initial focus will be on referrals that take place from the acute setting.

High-Level RM&R PRM Design Guiding Principles

“Increase capacity in the acute setting”

- Move patients who have completed their acute care phase to an ALC more quickly
- Increase the effectiveness of the referral process through standardization and streamlining of business and clinical processes so that patients do not need to be re-admitted to acute care
- Bring discharge planning to the forefront at the time of patient admission
- Improve patient safety by removing patients from the acute setting as soon as possible
- Flag “difficult to place” patients so that service gaps can be identified and addressed

“Discharge ALC patients more quickly and effectively”

- Effective resource matching with the ability to get a resource match for a patient more quickly
- Identify service needs for all ALC patients based on clinical criteria
- Leverage automation to minimize the dependency on manual processes for RM&R in order to free up human resources to perform more value-add work
- Develop actionable performance metrics so that referral issues are identified and actioned early

RM&R Objectives

Improvement

+

Standardization

+

Automation



“Increase Capacity”

“Discharge ALC Patients Faster”

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Leading Practices for the RM&R PRM

Achieving the benefits of a RM&R solution requires the redesign of business processes with a focus on patient flow and Care Management

Patient Flow and Care Management

- Care Management is the process that serves as the foundation for effective patient flow and facilitates the identification of the patient's needs for care/services across the continuum with a focus at the entry points and in acute and post-acute settings.
- Care Management is **proactive versus reactive** in its approach to patient management.
- Effective Care Management ensures patients have the **right care, at the right time, and in the right setting.**
- Care Management functions and processes are enabled utilizing clinical evidence-based criteria for LOC and technology
- The Care Manager serves as the point person accountable for all the following Care Management functions:
 - **Initial and concurrent clinical review** – focused process to assess LOC utilizing clinical evidence-based criteria to determine proactive discharge planning and identify ALC
 - **Discharge planning** – a structured and collaborative process for planning coordination of discharge or transfer needs
 - **Care facilitation** – focused process to assess, plan and coordinate patient care throughout their stay from admission to discharge
 - **Continuity management** – structured support and linkages between the acute setting, home and community
- The Care Manager role could be performed by existing personnel facilitating the referral (e.g., discharge planners, social workers or case managers) as deemed by LHIN/facility leadership.

Leading Practices for the RM&R PRM

Discharge planning is a key process to be redesigned in order to ensure a proactive approach (limiting the number of hand-offs and delays) to achieve the benefits of a RM&R solution.

Patient Flow and Discharge Planning

- **Discharge planning is one of the key Care Management functions**
 - It is initiated at the time of admission to an acute care setting or prior to admission for elective surgeries.
 - It is a structured and collaborative process for planning for the discharge or transfer needs of the patient.
 - It involves the early identification of potential discharge needs in order to facilitate the planning to ensure all post-acute care needs of the patient are addressed prior to the discharge and/or transition date.
 - Discharge planning occurs prior to the patient being identified as being ALC for the acute LOC.
 - Multiple discharge options are identified based on the complexity of the patient's needs to avoid delays in the transition process.
 - It **limits the number of hand-offs and delays** in the process
- Evidence-based criteria (e.g., InterQual or Medworxx) is utilized to support clinical judgment when identifying appropriate LOC for transitions and discharge options
 - Ongoing assessments of the patient using clinical review criteria support clinical judgment in the identification of the appropriate post-acute LOC based on the patient's needs and services required.
- The outcomes of effective discharge planning include:
 - Timely and safe discharge of the patient to an appropriate non-acute facility or to the patient's home
 - Increased satisfaction of the patient and family
 - Continuity of care between the hospital and the home and/or community

Core Elements and Benefits of a RM&R solution

*The **core elements** of a RM&R solution will enable a set of benefits that support the ER / ALC Wait Time Strategy through increased capacity, improved productivity and improved quality of care, and patient satisfaction.*

Core Elements

Improve Data Flow

- Interface with admission, discharge and transfer (ADT) systems in near-real time to decrease manual entry
- Ability to attach electronic copies of paper-based documents
- Integration of assessment forms and other medical documents into the eReferral
- Ability to develop discharge summary reports and documents
- Provides tracking and reporting tools

Streamline Communication

- Provides estimates of waitlist times for beds/services
- Automatically and electronically communicates patient referral to post-acute providers
- Supports proactive discharge planning by multiple team members
- Tracking and audit of referral communications
- Alerts online post-acute providers of referrals and alerts care managers/discharge planners of responses

Automate Processes

- Supports resource matching to align patient needs to service providers
- Assigns patients to discharge planner /care managers through worklists
- Integrates with clinical evidence criteria to support LOC
- Integrates with hospital/clinical/CCAC systems and supports documentation in the system

Benefits

Increase Capacity

- Decrease length of stay (LOS) – acute, intensive care unit (ICU) and emergency room (ER)
- Decrease ALC wait
- Improve response times in the referral process
- Improve inpatient capacity and throughput
- Increase capacity for admissions, ER visits and operating room (OR) cases

Improve Productivity

- Decrease delays and re-work
- Eliminate manual and paper processes
- Decrease multiple hand-offs
- Increase staff productivity and efficiency
- Decrease administrative costs

Improve Quality and Satisfaction

- Improve communication and accuracy in referral information
- Increase patient and family satisfaction
- Improve acute and post-acute provider satisfaction
- Improve comprehensive management reporting (e.g., waitlist and ALC)
- Improve predictive capabilities

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Process Flow Assumptions

The following general assumptions provide context across all of the referral pathways and are required to support the implementation of the RM&R solution.

Referral Step Timing

- All business processes begin with the client need identified* and end with services provided.
- The process flows are focused on moving the patient from acute to post-acute settings for the four in-scope pathways.
- The referral is initiated as soon as possible during the inpatient admission, but before an ALC designation.
- The CCAC is notified early in the process of the need for an assessment, when appropriate.

Process Ownership

- Process step ownership will be determined collaboratively by LHIN/ facility leadership.
- Care team members in the acute setting (hospital, CCAC) collectively manage the referral process.
- In some LHINs and hospitals, the CCAC case managers support all discharges that require a referral and this will remain unchanged.

Solution Access and Integration

- All team members responsible for the client's care will have at least viewing ability in the RM&R solution.
- All team members responsible for completion of (or contribution to) the referral should have viewing abilities in supporting systems and appropriate access to the RM&R solution.
- Users have access to any of the documents, which they will need to attach to the referral.
- The RM&R solution is integrated with hospital information systems and CCAC information systems in real time or near real time.
- Both sending and receiving organizations are live with a RM&R solution.

Compliance

- All legislative requirements remain unchanged.
- Physician consult processes/requirements remain unchanged.

** Client need identified occurs after assessments (e.g. eligibility, functional) have been completed and the post-acute LOC has been determined*

Waitlists, Waitlist Management and Service Volume Management

Waitlists are an output of Waitlist Management functions and are **in-scope** for the PRM. Waitlist Management and Service Volume Management functions are inputs to the eReferral process, but are not part of the PRM scope.

Waitlists (In-Scope)

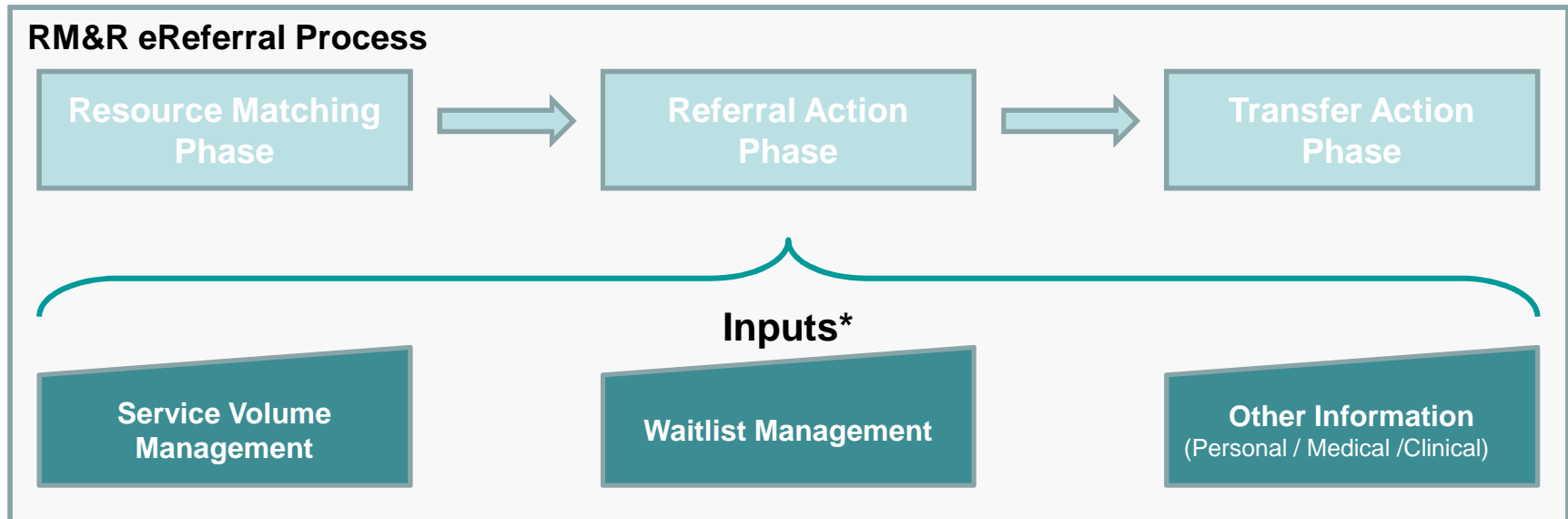
- The **RM&R solution will support the following waitlist functions:**
 - **Tracking of the waitlists** for the four in-scope pathways and all future pathways, including information such as ‘Who is waiting?’, and ‘How long have they been waiting?’
 - Support the **performance management functions to track the waitlist list indicators** for the pathways.
- The **PRM requires that, for all in-scope pathways** and future pathways, the **RM&R solution will be utilized to support the waitlist functions** and tracking and reporting of the waitlist performance indicators.

Waitlist Management & Service Volume Management Functions (Out-of-Scope)

- Waitlist management and service volume management functions are out-of-scope for the RM&R solution and the PRM.
- Waitlist management functions involve and consist of the following:
 - The utilization of criteria and priority factors, and is dependent on the availability of post-acute provider services and resources (e.g., staffing, equipment and space)
 - The functions are performed utilizing critical thinking skills and are enabled by technology supporting the waitlist functions (e.g. RM&R solution).
 - For the ‘Acute to Rehab’ and ‘Acute to CCC’ pathways, the referral destination facilities manage their own waitlists (e.g. criteria, prioritizing and tracking of the waitlist).
 - For the ‘Acute to LTC’ and ‘Acute to In-Home Services’, the CCAC manages the waitlist management functions.
- Service volume management is based on the service provider contracts and the volume of referrals to the post-acute service provider
 - For the ‘Acute to LTC’ and ‘Acute to In-Home Services’, the CCAC manages the service volume management functions.
- Waitlist management and service volume management functions are critical inputs to support RM&R reporting for the waitlist indicators, as defined by the Performance Management Framework.

RM&R Solution eReferral Process: Phases and Inputs

The three phases of the eReferral process involve multiple inputs at various intervals that are out-of-the scope of the RM&R solution.



*Waitlist Management & Service Volume Management Processes and Functions

- The RM&R solution will provide the functionality to support the tracking of the **waitlists** for the four in-scope pathways.
- **Waitlist management and service volume management processes functions are critical inputs** to support the RM&R reporting for the waitlist indicators, as defined by the Performance Management Framework, but are **out-of-scope for the RM&R PRM**.
- These functions serve as **key inputs into the eReferral process** at various intervals during the process depending on the pathway.
 - Interfaces should be considered if the process is system supported.

ALC RM&R as a Business Driver for Ontario's eReferral Specification

eHealth Ontario is in the process of creating an eReferral Specification that is driven in part by the data requirements defined in the ALC RM&R project.

Ontario eReferral Specification



The Ontario eReferral Specification will contain standardized interactions, data elements, supporting terminology and related technical artifacts, such as Extensible Markup Language (XML) schemas that will facilitate the exchange of referral requests between RM&R solutions in Ontario. This specification will be harmonized with other Ontario specifications, such as the Discharge Summary Specification, Client Registry Specification and Provider Registry Specification, as well as with other relevant pan-Canadian specifications, where applicable.

- Currently CCO, in partnership with eHealth Ontario, leads the ALC RM&R project in establishing the PRM for ALC RM&R implementation.
- The ALC RM&R PRM will enable resource matching and referrals originating from Acute Care to Rehab, CCC, LTC and for In-Home Services.
- The Ontario eReferral Specification will be created to support all referral pathways.
- Each of the four pathways examined as part of the ALC RM&R project has an associated set of data elements that support specific steps in the referral pathway process.
- Although individual RM&R solutions may capture these data elements in different formats, each RM&R solution should have the ability to map these data elements to elements that will be defined in the Ontario eReferral Specification.

What has been done to date for Ontario's eReferral Specification?

The specification is created using eHealth Ontario's Standards methodology that will enable interoperability and support eHealth implementations.

Ontario eReferral Specification Work to Date



- Gathered requirements from CCACs. Rehab Inpatient Services and CCC
- Conducted gap-fit analysis with the latest version of the pan-Canadian eReferral Specification
- Created a draft data model based on the pan-Canadian eReferral Specification to address gaps

Next Steps Toward the Completion of the Ontario eReferral Specification

Creation of the Ontario eReferral specification will focus on a number of aspects, such as scope (e.g. business cases beyond the four pathways, terminology, attributes, data types and messaging).

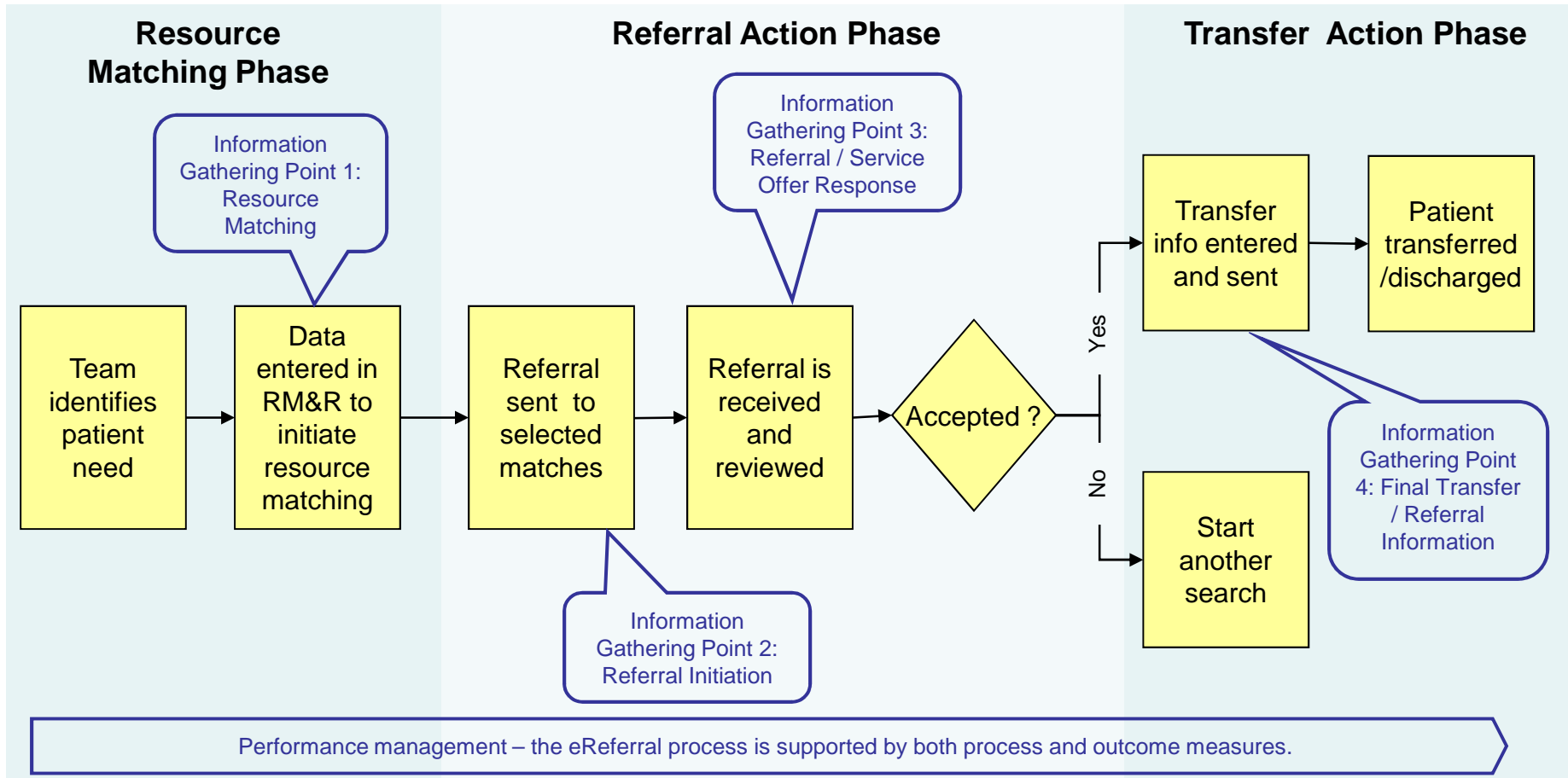
Ontario eReferral Specification Next Steps



- Finalize eHealth Ontario eReferral scope, use cases and assumptions
- Define storyboards
- Align the eReferral model with the Discharge Summary Model
- Define messaging (interactions and create dynamic models)
- Review outcomes of the ALC RM&R sub-group sessions and additional referral forms, update data elements spreadsheet and gap analysis
- Harmonize with other eHealth Ontario standards for (i.e. Client Registry, Provider Registry, etc.)
- Create initial draft of the Ontario eReferral specification
- Establish provincial review groups and validate specification with appropriate stakeholders in Ontario
- Undergo eHealth Ontario approval process
- Submit extensions and issues with Infoway Standards Collaborative
- Publish reconciled Ontario eReferral specification - including technical artifacts (e.g. XML schemas, etc.)

High-Level Future State eReferral Process

The high-level eReferral process is common to the four in-scope pathways and includes three phases that serve as the basis for the other work streams.



Acute to Rehab: Definition and Scope

•Definition: Rehab

•A progressive, dynamic, goal-oriented and often time-limited process, which enables an individual with an impairment to identify and reach his/her optimal mental, physical, cognitive and/or social functional level. Rehabilitation provides opportunities for the individual, the family and the community to accommodate a limitation or loss of function and aims to facilitate social integration and independence.

•Source: *GTA Rehab Network, Rehab Definitions Conceptual Framework April 2008*

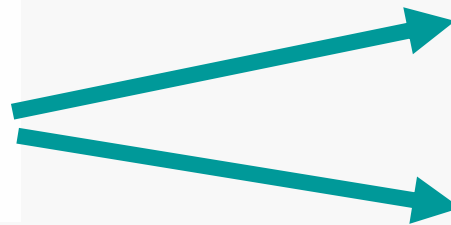
•<http://www.gtarehabnetwork.ca/downloads/rehab-definitions-conceptual-framework.pdf>

•Scope

•The acute to Rehab pathway encompasses the movement of a patient from an acute, inpatient adult medical, surgical or intensive care/step down unit bed to an inpatient rehab bed, in either a free-standing facility or a unit in the current or other hospital. The pathway does not include patients moving from obstetrics or mental health.



**Acute Care
Hospital**



**Inpatient Rehab
unit in Acute Care
Hospital**

**Inpatient Rehab in
free-standing Rehab
Hospital**

Acute to Rehab Unique Features

While the high-level referral process is standardized across the three phases, each pathway has unique features.

- **Process Flow Assumptions**

- The CCAC is involved early in the process, where applicable (e.g., in some LHINs and hospitals the CCAC case managers support the Acute to Rehab pathway).

- **Time Frames**

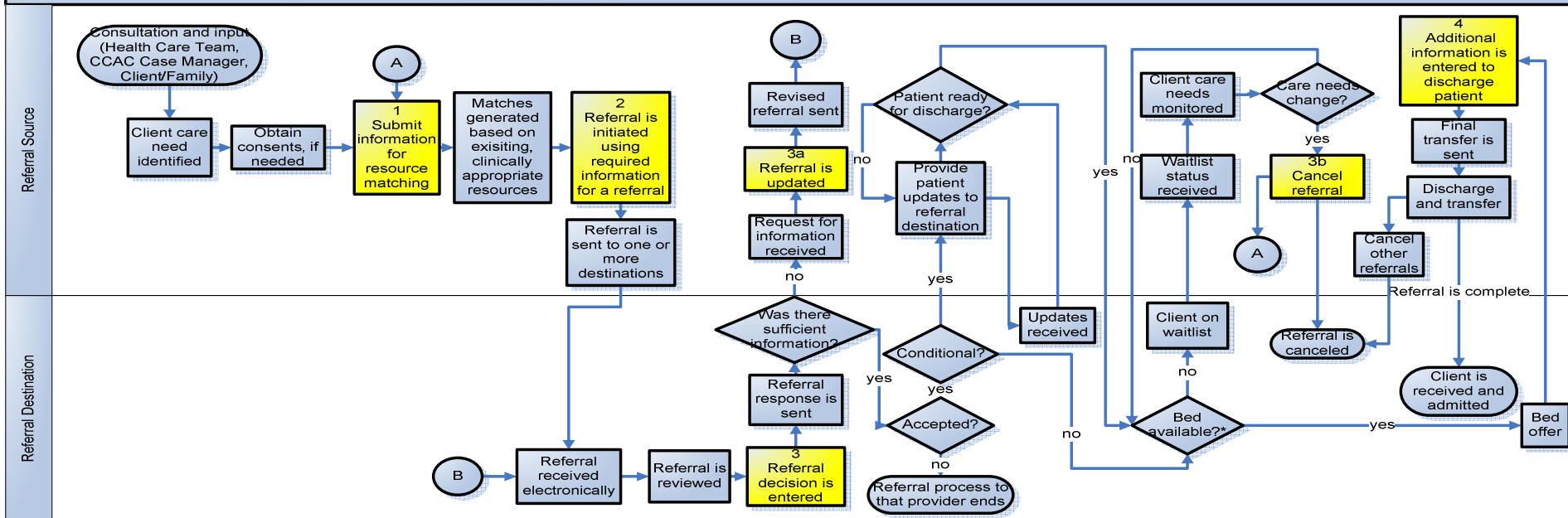
- Referral is sent from acute setting once need is identified, but at least three to five days ahead of anticipated discharge.
- Receiving facilities to respond within one to two business days.

- **Differences from other process flows**

- Rehab and CCC process flow steps are identical with varying information needs to be entered at the information gathering points.
- Rehab and CCC process flows include an additional referral response of Accepted – Conditionally.

Acute to Rehab Business Process Flow

Acute to Rehab Electronic Resource Matching and Referral Process



Legend

Yellow boxes indicate information gathering points

- * Bed available refers to whether a bed is available for the client, after bed matching has been performed.
- 1 – Resource Matching - Submit sufficient information to initiate resource matching to identify potential providers
- 2 – Referral Initiation - Referral is initiated using required information for a referral.
- 3 – Referral decision – Referral destination enters the referral decision.
 - 3a – Missing or supplemental information required
 - 3b – Referral cancellation
- 4 – Transfer Information – Balance of information needed for transfer is entered.

Acute to Rehab: Referral Resource Matching

Information Gathering Point 1

Working Definition for Resource Matching: The process of using the RM&R solution to query a directory of facilities, programs and services that may meet the patient's needs within the identified LOC.

Question: What is the minimum information required to perform the Resource Matching process?

Category	Data Element	Description & Examples
Referral Information	Referral Type	The referral destination type (e.g. Acute to Rehab)
	Requested Service or Program	A specific program/service that the patient requires. (e.g. high/low tolerance within a specific program – acquired brain injury (ABI), amputee, burns, cardiac, spinal cord, trauma, stroke, other). LHINs will determine what specific services and programs are offered
	Additional Service Information / Special Needs	Additional information about the service that the patient requires. (e.g. tracheotomy, intravenous, oxygen, enteral feeding, dialysis, ventilation, specific equipment needs including transfer/mobility, other). LHINs will determine what specific additional services are offered
	Age	The patient's age. This is used to determine service / program eligibility
	Postal Code	Geographic area where the client would prefer the service to take place
	Accommodation Type	A specific type of accommodation that the patient would prefer (e.g. private vs. ward)
	Gender	The sex of the patient

Acute to Rehab: Referral Initiation

Information Gathering Point 2 (1 of 3)

Working Definition for Referral Initiation: This information allows a facility or organization to determine whether to accept or decline a referral.

Question: What is the minimum information required to initiate a referral?

Category	Data Element	Description & Examples
Referral Information	Resource Matching Data Elements	Appropriate data elements from resource matching step including referral type, program/service, additional service information, date of birth, postal code, accommodation type, gender
	Provider / Service Location	Selected Rehab facility/location identified during Resource Matching
	Service Requested Start Date	Expected hospital discharge date
	Expected Length of Stay	Expected length of stay at Rehab facility
	Referral Create Date	The date that the referral is created
	Referral Send Date	The date the referral is sent
	Referring Facility	The acute facility where the referral originates
	Referral Completed by Person	Contact information of the person that created the referral (e.g. name, phone)
	Reason for Referral	The reason the referral was created (e.g. needs therapy for paralysis due to stroke)

Acute to Rehab: Referral Initiation

Information Gathering Point 2 (2 of 3)

Working Definition for Referral Initiation: This information allows a facility or organization to determine whether to accept or decline a referral.

Question: What is the minimum information required to initiate a referral?

Category	Data Element	Description & Examples
Personal Information	Patient Identifier	Ontario Health Insurance Plan (OHIP) number or other provincial health number. Note: other patient information (e.g. name, phone, address, language) is expected to come from an admit/discharge transfer (ADT) system
Medical Information	Infectious Diseases	Infectious diseases that the patient may currently have (e.g. MRSA, VRE, C-Difficile, H1N1)
	Diagnosis	Patient diagnosis information
	Medical History	Medical history relevant to the referral (e.g. functional history, family history, height and weight for potential equipment requirements)
Clinical Information	Rehab Goals	An indication of the patient's rehab goals. Does the patient have a specific goal (e.g. physiotherapy (PT), occupational therapy (OT), speech language pathology (SLP) progress and plan)
	Participation Level	An indication that the patient has the ability to receive therapy (e.g. sessions/day, times/week, minutes/session)
	Behaviours, concerns, issues and risks	An indication of what behaviours, concerns, issues and risks that may impact the ability to receive rehab
	Selected Functional Ability	An indication of the patient's level of daily living activities

Acute to Rehab: Referral Initiation

Information Gathering Point 2 (3 of 3)

Working Definition for Referral Initiation: This information allows a facility or organization to determine whether to accept or decline a referral.

Question: What is the minimum information required to initiate a referral?

Category	Data Element	Description & Examples
Clinical Information	Cognitive Status	An indication of a patient's ability to follow instructions and retain new learning
	Expected Post-Rehab Discharge Destination	The expected discharge destination after rehab is complete (e.g. home or LTC)

Acute to Rehab: Referral Response

Information Gathering Point 3

Working Definition for Referral Response: The process of accepting or declining a referral.

Question: What is the minimum information required to respond to a referral?

Category	Data Element	Description & Examples
Referral Information	Referral Response	The response to the referral request from the referral destination e.g. Accepted – Bed Available, Accepted – Conditionally, Accepted - Waitlisted, Declined, Send-back
	Referral Response Date	The date the referral is accepted or declined. This is a solution generated date for key performance indicator (KPI) purposes
	Estimated Wait Time	The estimated wait time for the referral if the referral response is accepted. e.g. a week, a month, > 6 months, > year
	Time for Arrival at Facility	The suggested transfer time to the referral destination if the referral is “Accepted”. This ensures that a physician is on-site at the receiving facility to write orders, if required
	Provided Decline Reason	The reason for declining a referral, if the referral is declined
	Notes	A note field to capture the following: if referral is “Declined”, additional information to explain reason for decline. If referral is “Send-back”, a note that indicates what information is missing. If referral is “Accepted Conditionally”, a note indicating what the condition for acceptance is

Acute to Rehab: Send Back Information Gathering Point 3a

Working Definition for Send Back: The process of providing additional or missing information that is required to make an accept or decline decision.

Question: What is the missing or additional information required to complete the request in the notes field of the Referral Response?

Category	Data Element	Description & Examples
Referral Information	Additional or Missing information	Any information that was required but not provided in information gathering step 2

Acute to Rehab: Cancel Referral Information Gathering Point 3b

Working Definition for Cancel Referral: The process of cancelling a referral because the patient's care requirements have changed such that the initial referral is no longer appropriate.

Question: What is the minimum information required to cancel a referral?

Category	Data Element	Description & Examples
Referral Information	Referral Cancel	An indication that the referral initiator has decided to cancel the referral
	Referral Cancel Date	The date the referral is cancelled by the referral initiator
	Provided Cancel Reason	The reason that the referral initiator is cancelling the referral (e.g. patient is deceased)

Acute to Rehab: Transfer Information

Information Gathering Point 4 (1 of 2)

Working Definition for Transfer Information: This additional updated information is needed to enable timely and effective care when the patient is ready for transfer from the acute facility to a post-acute facility.

Question: What is the minimum information required to transfer a patient?

Category	Data Element	Description & Examples
Referral Information	Referral Finalization Date	The date the transfer information is added to the referral
Emergency Contact Information	Non-patient Contact Information	Contact information for relatives of the patient. (e.g. name, phone; relationship to patient - e.g. substitute decision maker, power of attorney; public guardian & trustee)
Physician Information	Physician ID / OHIP Billing Number Physician Type	Physician information and type (e.g. attending, referring, family)
Other Practitioners	Other Practitioners that provided information in the referral	Contact information for other practitioners involved in the referral (e.g. case manager, nurse, therapists, other)
Financial Information	Payment Type and Insurance Information	The method that will be used to pay for the service (e.g. OHIP, Workplace Safety and Insurance Board (WSIB), insurance, self) If the payment is via insurance, the additional insurance information that is required (e.g. company, Policy No., Group No.)
Consent Information	Consent	Required consents (e.g. consent to referral, consent to use patient's personal health information (PHI) for purposes of the referral)

Acute to Rehab: Transfer Information Information Gathering Point 4 (2 of 2)

Working Definition for Transfer Information: This additional updated information is needed to enable timely and effective care when the patient is ready for transfer from the acute facility to a post-acute facility.

Question: What is the minimum information required to transfer a patient?

Category	Data Element	Description & Examples
Discharge Information	Discharge Instructions Medication Administration list Discharge Medication list Equipment and Supplies	Discharge information
Observations and Finding	Allergies and adverse reactions	Information that describes patient allergies and adverse reactions

Acute to Complex Continuing Care (CCC): Definition and Scope

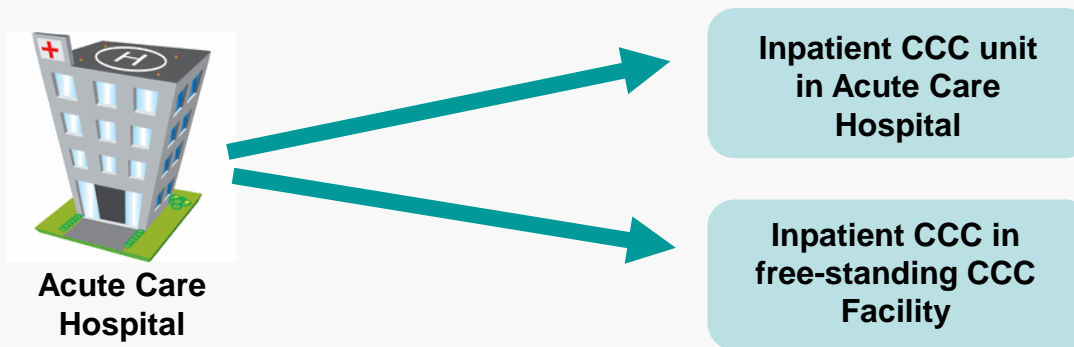
Definition: CCC

Complex continuing care is a specialized program of care providing programs for medically complex patients whose condition requires a hospital stay, regular onsite physician care and assessment, and active care management by specialized staff.

Source: http://www.oha.com/CurrentIssues/Issues/eHealth/Documents/Optimizing_the_Role_of_CCCandRehab.pdf

Scope

The acute to CCC pathway encompasses the movement of a patient from an acute, inpatient adult medical or surgical unit bed to an inpatient CCC bed, in either a free-standing facility or a unit in the current or other hospital. The pathway does not include patients moving from obstetrics or mental health.



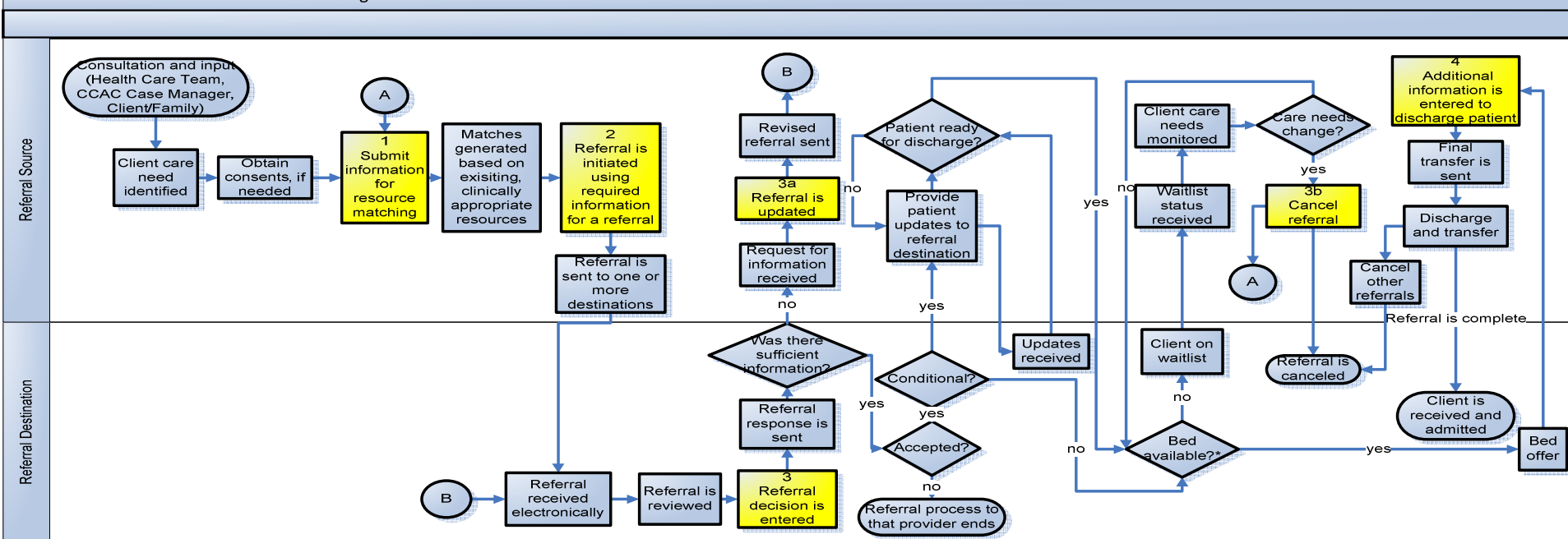
Acute to CCC Unique Features

While the high-level referral process is standardized across the three phases, each pathway has unique features.

- **Process Flow Assumptions**
 - The CCAC is involved early in the process, where applicable (e.g., in some LHINs and hospitals the CCAC case managers support the Acute to CCC pathway).
- **Time Frames**
 - Referral is sent from acute setting once need is identified, but at least three to five days ahead of anticipated discharge.
 - Receiving facilities to respond within one to two business days.
- **Differences from other process flows**
 - Rehab and CCC process flow steps are identical with varying information needs to be entered at the information gathering points.
 - Rehab and CCC process flows include an additional referral response of Accepted – Conditionally.

Acute to CCC Business Process Flow

Acute to CCC Electronic Resource Matching and Referral Process



Legend

Yellow boxes indicate information gathering points

- * Bed available refers to whether a bed is available for the client, after bed matching has been performed.
- 1 – Resource Matching - Submit sufficient information to initiate resource matching to identify potential providers
- 2 – Referral Initiation - Referral is initiated using required information for a referral
- 3 – Referral decision – Referral destination enters the referral decision
 - 3a – Missing or supplemental information required
 - 3b – Referral cancellation
- 4 – Transfer Information – Balance of information needed for transfer is entered

Acute to CCC: Referral Resource Matching

Information Gathering Point 1

Working Definition for Resource Matching: The process of using the RM&R solution to query a directory of facilities, programs and services that may meet the patient's needs within the identified LOC.

Question: What is the minimum information required to perform the Resource Matching process?

Category	Data Element	Description & Examples
Referral Information	Referral Type	The referral destination type (e.g. Acute to CCC)
	Requested Service or Program	A specific program/service that the patient requires (e.g. general services; palliative care; complex medical services; dialysis; neuro; ventilator; low intensity, long duration rehabilitation; wound care; supportive care, respiratory care, bariatric, respite). LHINs will determine what specific services and programs are offered
	Additional Service Information / Special Needs	Additional information about the services that the patient requires (e.g. IV meds, pain pump, central line, suctioning, blood transfusions, oxygen, feeding tube, ventilator, other) or specialized care that the patient may require (e.g. coma, quadriplegic, dialysis, wound care, burns, radiation, end of life care, other). LHINs will determine what specific additional services are offered
	Age	The patient's age. This is used to determine service / program eligibility
	Postal Code	Geographic area where the client would prefer the service to take place
	Accommodation Type	A specific type of accommodation that the patient would prefer (e.g. private vs. ward)
	Gender	The sex of the patient

Acute to CCC: Referral Initiation

Information Gathering Point 2 (1 of 3)

Working Definition for Referral Initiation: This information allows a facility or organization to determine whether to accept or decline a referral.

Question: What is the minimum information required to initiate a referral?

Category	Data Element	Description & Examples
Referral Information	Resource Matching Data Elements	Appropriate data elements from resource matching step including referral type, program/service, additional service information, date of birth, postal code, accommodation type, gender
	Provider / Service Location	Selected CCC facility/location identified during resource matching
	Service Requested Start Date	Expected hospital discharge date
	Expected Length of Stay	Expected length of stay at CCC facility
	Referral Create Date	The date that the referral is created
	Referral Send Date	The date the referral is sent
	Referring Facility	The acute facility where the referral originates
	Referral Completed by Person	Contact information of the person that created the referral. (e.g. name, phone number)
	Reason for Referral	The reason the referral was created (e.g. patient is in a coma)

Acute to CCC: Referral Initiation

Information Gathering Point 2 (2 of 3)

Working Definition for Referral Initiation: This information allows a facility or organization to determine whether to accept or decline a referral.

Question: What is the minimum information required to initiate a referral?

Category	Data Element	Description & Examples
Personal Information	Patient Identifier	OHIP number or other provincial health number. Note: other patient information (e.g. name, phone, address, language) is expected to come from an ADT system
Medical Information	Infectious Diseases	Infectious diseases that the patient may currently have (e.g. MRSA, VRE, C-Difficile, H1N1)
	Diagnosis	Patient diagnosis information
	Medical History	Medical history relevant to the referral (e.g. functional history, family history, height and weight for potential equipment requirements)
Clinical Information	Care Goals	An indication of the patient's care goals. Does the patient have a specific goal (e.g. physiotherapy (PT), occupational therapy (OT), speech language pathology (SLP) progress and plan)
	Participation Level	An indication that the patient has the ability to receive therapy (e.g. sessions/day, times/week, minutes/session)
	Behaviours, concerns, issues and risks	An indication of what behaviours, concerns, issues and risks that may impact the ability to receive care
	Selected Functional Ability	An indication of the patient's level of activities of daily living. LHINs will determine which specific functional ability should be assessed, e.g. late loss activities of daily living (ADLs)

Acute to CCC: Referral Initiation Information Gathering Point 2 (3 of 3)

Working Definition for Referral Initiation: This information allows a facility or organization to determine whether to accept or decline a referral.

Question: What is the minimum information required to initiate a referral?

Category	Data Element	Description & Examples
Clinical Information	Cognitive Status	An indication of a patient' ability to follow instructions and retain new learning

Acute to CCC: Referral Response

Information Gathering Point 3

Working Definition for Referral Response: The process of accepting or declining a referral.

Question: What is the minimum information required to respond to a referral?

Category	Data Element	Description & Examples
Referral Information	Referral Response	The response to the referral request from the referral destination e.g. Accepted – Bed Available, Accepted – Conditionally, Accepted - Waitlisted, Declined, Send-back
	Referral Response Date	The date the referral is accepted or declined. This is a solution generated date for KPI purposes
	Estimated Wait Time	The estimated wait time for the referral if the referral response is accepted e.g. a week, a month, > 6 months, > year
	Time for Arrival at Facility	The suggested transfer time to the referral destination if the referral is Accepted. This ensures that a physician is on-site at the receiving facility to write orders, if required
	Provided Decline Reason	The reason for declining a referral, if the referral is declined
	Notes	A note field to capture the following: If referral is “Declined”, additional information to explain reason for decline. If referral is “Send-back”, a note that indicates what information is missing. If referral is “Accepted-Conditionally”, a note indicating what the condition for acceptance is

Acute to CCC: Send Back Information Gathering Point 3a

Working Definition for Send Back: The process of providing additional or missing information that is required to make an accept or decline decision.

Question: What is the missing or additional information required to complete the request in the notes field of the Referral Response?

Category	Data Element	Description & Examples
Referral Information	Additional or Missing information	Any information that was required but not provided in information gathering step 2

Acute to CCC: Cancel Referral Information Gathering Point 3b

Working Definition for Cancel Referral: The process of cancelling a referral because the patient's care requirements have changed such that the initial referral is no longer appropriate.

Question: What is the minimum information required to cancel a referral?

Category	Data Element	Description & Examples
Referral Information	Referral Cancel	An indication that the referral initiator has decided to cancel the referral
	Referral Cancel Date	The date the referral is cancelled by the referral initiator
	Provided Cancel Reason	The reason that the referral initiator is cancelling the referral (e.g. patient is deceased)

Acute to CCC: Transfer Information

Information Gathering Point 4 (1 of 2)

Working Definition for Transfer Information: This additional updated information is needed to enable timely and effective care when the patient is ready for transfer from the acute facility to a post-acute facility.

Question: What is the minimum information required to transfer a patient?

Category	Data Element	Description & Examples
Referral Information	Referral Finalization Date	The date the transfer information is added to the referral
Emergency Contact Information	Non-patient Contact Information	Contact information for relatives of the patient. (e.g. name, phone; relationship to patient - e.g. substitute decision maker, power of attorney; public guardian & trustee)
Physician Information	Physician ID / OHIP Billing Number Physician Type	Physician information and type (e.g. attending, referring, family)
Other Practitioners	Other Practitioners that provided information in the referral	Contact information for other practitioners involved in the referral (e.g. case manager, nurse, therapists, other)
Financial Information	Payment Type and Insurance Information	The method that will be used to pay for the LTC service (e.g. OHIP, WSIB, insurance, self) If the payment is via insurance, the additional insurance information that is required (e.g. company, Policy No., Group No.)
Consent Information	Consent	Required consents (e.g. consent to referral, consent to use patient's PHI for purposes of the referral, consent to co-payment)

Acute to CCC: Transfer Information Information Gathering Point 4 (2 of 2)

Working Definition for Transfer Information: This additional updated information is needed to enable timely and effective care when the patient is ready for transfer from the acute facility to a post-acute facility.

Question: What is the minimum information required to transfer a patient?

Category	Data Element	Description & Examples
Discharge Information	Discharge Instructions Medication Administration list Discharge Medication list Equipment and Supplies	Discharge information
Observations and Finding	Allergies and adverse reactions	Information that describes patient allergies and adverse reactions

Acute to Long-Term Care (LTC): Definition and Scope

•Definition: LTC

•A LTC home provides care and services for people who no longer are able to live independently or who require on-site nursing care, 24-hour supervision or personal support. Nursing homes under the *Nursing Homes Act*, approved charitable homes for the aged under the *Charitable Institutions Act* and homes under the *Homes for the Aged and Rest Homes Act* are all LTC homes.

•Source: MOHLTC website: http://www.health.gov.on.ca/english/public/program/ltc/28_pr_glossary.html

•Scope

•The acute to LTC pathway encompasses the movement of a patient from an acute, inpatient adult medical or surgical unit bed to a LTC home, coordinated through a CCAC. The pathway does not include patients moving from obstetrics or mental health.



Acute Care
Hospital



CCAC



Long-Term Care
Home

Acute to LTC Unique Features

While the high-level referral process is standardized across the three phases, each pathway has unique features.

- **Process Flow Assumptions**

- The CCAC is mandated to manage and support the acute to LTC referral pathway
- At a client request, a referral may be sent to a LTC home that was not part of the resource match results
- When a client moves to a LTC facility, the remaining referrals remain active pending confirmation of client placement satisfaction, this process is managed by CCAC

- **Time Frames**

- Referral is sent from acute setting/CCAC case manager once need is identified, but at least three to five days ahead of anticipated discharge
- Receiving facilities to respond within five days*
- Clients respond to a bed offer within 24 hours

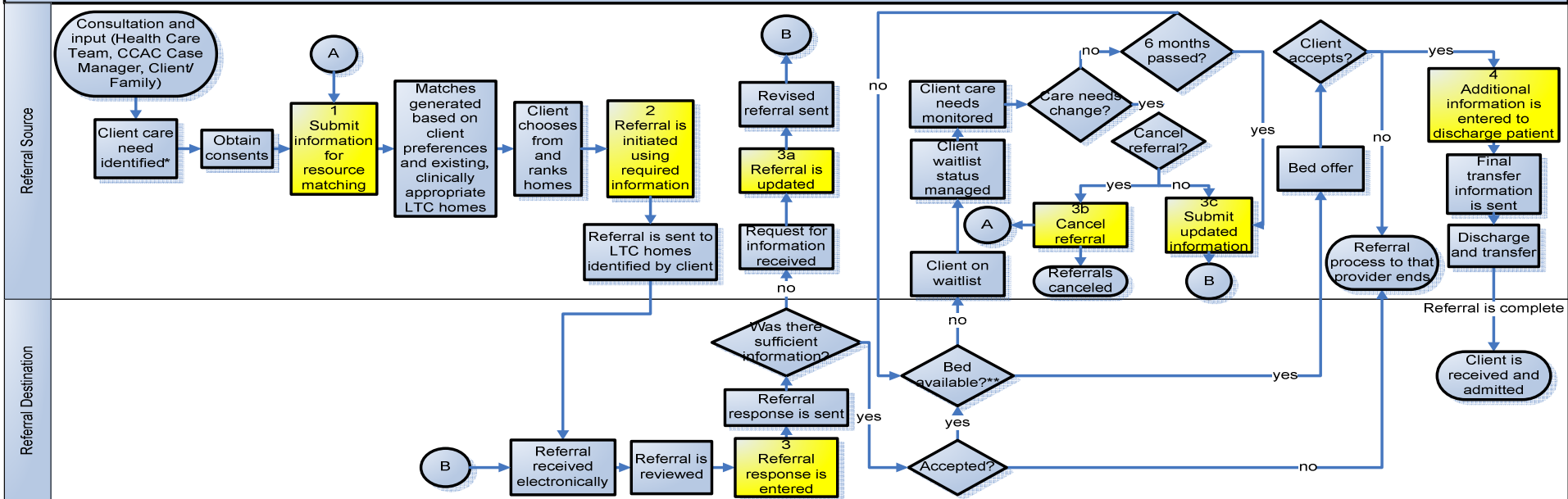
- **Differences from other process flows**

- LTC process flow steps include reassessment for patients on the waitlist for six months
- LTC process flow includes the client choice and ranking for which LTC homes receive a referral
- LTC process flow includes the option for the client to decline a bed offer

* Legislated by province

Acute to LTC Business Process Flow

Acute to Long-Term Care Electronic Resource Matching and Referral Process



Legend

Yellow boxes indicate information gathering points

- * CCAC Case Manager is notified of the potential referral by health care team and manages the referral.
- ** Bed available refers to whether a bed is available for a client, after bed matching is performed.
- 1 – Resource Matching - Submit sufficient information to initiate resource matching to identify potential providers
- 2 – Referral Initiation - Referral is initiated using required information for a referral.
- 3 – Referral decision – Referral destination enters the referral decision.
 - 3a – Missing or supplemental information needed
 - 3b – Updated information required after 6 months
 - 3c – Referral cancellation
- 4 – Transfer Information – Balance of information needed for transfer is entered.

Acute to LTC: Referral Resource Matching

Information Gathering Point 1

Working Definition for Resource Matching: The process of using the RM&R solution to query a directory of facilities, programs and services that may meet the patient's needs within the identified LOC.

Question: What is the minimum information required to perform the Resource Matching process?

Category	Data Element	Description & Examples
Referral Information	Referral Type	The referral destination type (e.g. Acute to LTC)
	Requested Service or Program	A specific program/service that the patient requires (e.g. Long-Term Care, short stay, convalescent care)
	Additional Service Information / Special Needs	Additional information about the service that the patient requires. (e.g. catheter, dialysis, feeding tubes, inhalation therapy, ostomy, oxygen, respirator, suction, wandering, secure unit, wheelchairs, wound care, recreation, physiotherapy, occupational therapy, speech language therapy, etc.)
	Age	The patient's age which is used to determine service / program eligibility.
	Postal Code	Geographic area where the client would prefer the service to take place
	Accommodation Type	A specific type of accommodation that the patient would prefer (e.g. private vs. ward)
	Gender	The sex of the patient

Acute to LTC: Referral Initiation

Information Gathering Point 2

Working Definition for Referral Initiation: This information allows a facility or organization to determine whether to accept or decline a referral.

Question: What is the minimum information required to initiate a referral?

Category	Data Element	Description & Examples
Referral Information	Resource Matching Data Elements	Appropriate data elements from the resource matching step, including referral type, program/service, additional service information, date of birth, postal code, accommodation type, gender
	Provider / Service Location	The patient's LTC home choice list
	Service Requested Start Date	Expected hospital discharge date
	Expected Length of Stay	Expected length of stay if the program or service type is short stay or convalescent care
	Referral Create Date	The date that the referral is created
	Referral Send Date	The date the referral is sent
	Referring Facility	The acute facility where the referral originates
	Referral Completed by Person	Contact information of the person that created the referral (e.g. name, phone)
	Priority Category	The priority category of the referral (e.g. 1A, 1A1, 1B, 2, 3)
Reason for Referral	The reason the referral was created (e.g. needs convalescent care to regain strength)	

Acute to LTC: Referral Initiation

Information Gathering Point 2

Working Definition for Referral Initiation: This information allows a facility or organization to determine whether to accept or decline a referral.

Question: What is the minimum information required to initiate a referral?

Category	Data Element	Description & Examples
Personal Information	Patient Identifier	OHIP number or other provincial health number. Note: other patient information (e.g. name, phone, address, language) is expected to come from an ADT system
Emergency Contact Information	Non-patient Contact Information	Name, phone; relationship to patient - e.g. substitute decision maker, power of attorney; public guardian & trustee
Consent	Consents	Consent to the referral, consent to the use of referral information
Observations and Finding	Infectious Diseases	Infectious diseases that the patient may currently have (e.g. MRSA, VRE, C-Difficile, H1N1)
	Health Report	A report on the patient's health. This includes diagnosis, medical history, allergies and adverse reactions
	RAI Assessment	The resident assessment instrument document
	Capacity Assessment	A standard evaluation of a patient's capacity to make a decision as to whether they should go to LTC or not
	Height and Weight	The patient's height and weight
	Behavioural Assessment	An optional assessment indicating whether a patient may have any behavioural issues that a LTC facility should be aware of

Acute to LTC: Referral Response Information Gathering Point 3

Working Definition for Referral Response: The process of accepting or declining a referral.

Question: What is the minimum information required to respond to a referral?

Category	Data Element	Description & Examples
Referral Information	Referral Response	The response to the referral request from the referral destination (e.g. Accepted – Bed Available, Accepted – Waitlisted, Declined, Send-back)
	Referral Response Date	The date the referral is accepted or declined. This is a solution generated date for KPI purposes
	Estimated Wait Time	The estimated wait time for the referral if the referral response is accepted (e.g. a week, a month, > 6 months, > year)
	Provided Decline Reason	The reason for declining a referral, if the referral is declined
	Notes	A note field to capture the following: If referral is “Declined”, additional information to explain reason for decline. If referral is “Send-back”, a note that indicates what information is missing

Acute to LTC: Send Back Information Gathering Point 3a

Working Definition for Send Back: The process of providing additional or missing information that is required to make an accept or decline decision.

Question: What is the missing or additional information required to complete the request in the notes field of the Referral Response?

Category	Data Element	Description & Examples
Referral Information	Additional or Missing information	Any information that was required but not provided in information gathering step 2

Acute to LTC: Cancel Referral

Information Gathering Point 3b

Working Definition for Cancel Referral: The process of cancelling a referral because the patient's care requirements have changed such that the initial referral is no longer appropriate.

Question: What is the minimum information required to cancel a referral?

Category	Data Element	Description & Examples
Referral Information	Referral Cancel	An indication that the referral initiator has decided to cancel the referral
	Referral Cancel Date	The date the referral is cancelled by the referral initiator
	Provided Cancel Reason	The reason that the referral initiator is cancelling the referral (e.g. patient is deceased)

Acute to LTC: Updated Referral Information

Information Gathering Point 3c

Working Definition for Updated Referral Information: The process of providing updated referral information at six month intervals to ensure that the referral information is current.

Question: What is the minimum information required to update the referral?

Category	Data Element	Description & Examples
Emergency Contact Information	Non-patient Contact Information	Name, phone; relationship to patient - e.g. substitute decision maker, power of attorney; public guardian & trustee
Consent	Consents	Consent to the referral, consent to the use of referral information
Observations and Finding	Infectious Diseases	Infectious diseases that the patient may currently have (e.g. MRSA, VRE, C-Difficile, H1N1)
	Health Report	A report on the patient's health. This includes diagnosis, medical history, allergies and adverse reactions
	RAI Assessment	The Resident Assessment Instrument document
	Capacity Assessment	A standard evaluation of a patient's capacity to make a decision as to whether they should go to LTC or not
	Height and Weight	The patient's height and weight
	Behavioural Assessment	An optional assessment indicating whether a patient may have any behavioural issues that a LTC facility should be aware of

Acute to LTC: Transfer Information

Information Gathering Point 4 (1 of 2)

Working Definition for Transfer Information: This additional updated information is needed to enable timely and effective care when the patient is ready for transfer from the acute facility to a post-acute facility.

Question: What is the minimum information required to transfer a patient?

Category	Data Element	Description & Examples
Referral Information	Referral Finalization Date	The date the transfer information is added to the referral
Emergency Contact Information	Non-patient Contact Information	Contact information for relatives of the patient. (e.g. name, phone; relationship to patient - e.g. substitute decision maker, power of attorney; public guardian & trustee)
Physician Information	Physician ID / OHIP Billing Number Physician Type	Physician information and type (e.g. attending, referring, family)
Other Practitioners	Other Practitioners Information	Contact information for other practitioners involved in the referral (e.g. case manager, nurse, therapists, other)
Finance Information	Payment Type and Insurance Information	The method that will be used to pay for the LTC service (e.g. OHIP, WSIB, insurance, self) If the payment is via insurance, the additional insurance information that is required (e.g. company, Policy No., Group No.)
Medical Orders	Medical Orders	Note: expectation is that medical orders will be an attachment to the referral or faxed to the referral destination

Acute to LTC: Transfer Information Information Gathering Point 4 (2 of 2)

Working Definition for Transfer Information: This additional updated information is needed to enable timely and effective care when the patient is ready for transfer from the acute facility to a post-acute facility.

Question: What is the minimum information required to transfer a patient?

Category	Data Element	Description & Examples
Discharge Information	Discharge Instructions Medication Administration list Discharge Medication list Equipment and Supplies	Additional information about the patient for discharge purposes

Acute to In-Home Services: Definition and Scope

Definition: Home with Services

“Home with Services” describes a destination where a patient resides at home after discharge from an institution and receives professional services contracted through a CCAC. Services can include nursing, personal support, physiotherapy, occupational therapy, speech-language therapy, social work, nutritional counseling or medical supplies and equipment.

Scope

The acute to In-Home Services pathway encompasses the movement of a patient from an acute, inpatient adult medical or surgical unit bed to home with services contracted through the CCAC. The pathway does not include patients moving from obstetrics or mental health.



**Acute Care
Hospital**



CCAC



**Home with
Services**

Acute to In-Home Services Unique Features

While the high-level referral process is standardized across the three phases, each pathway has unique features

- **Process Flow Assumptions**

- The CCAC is mandated to manage and support the acute to In-Home Services referral pathway and service provider contracts (e.g., service volume).
- Resource matching for In-Home Services is performed in the RM&R solution and offers/referrals are sent according to LHIN-specific contract schedules.
- A client may be discharged from the acute setting before services are arranged or available through a waitlist.

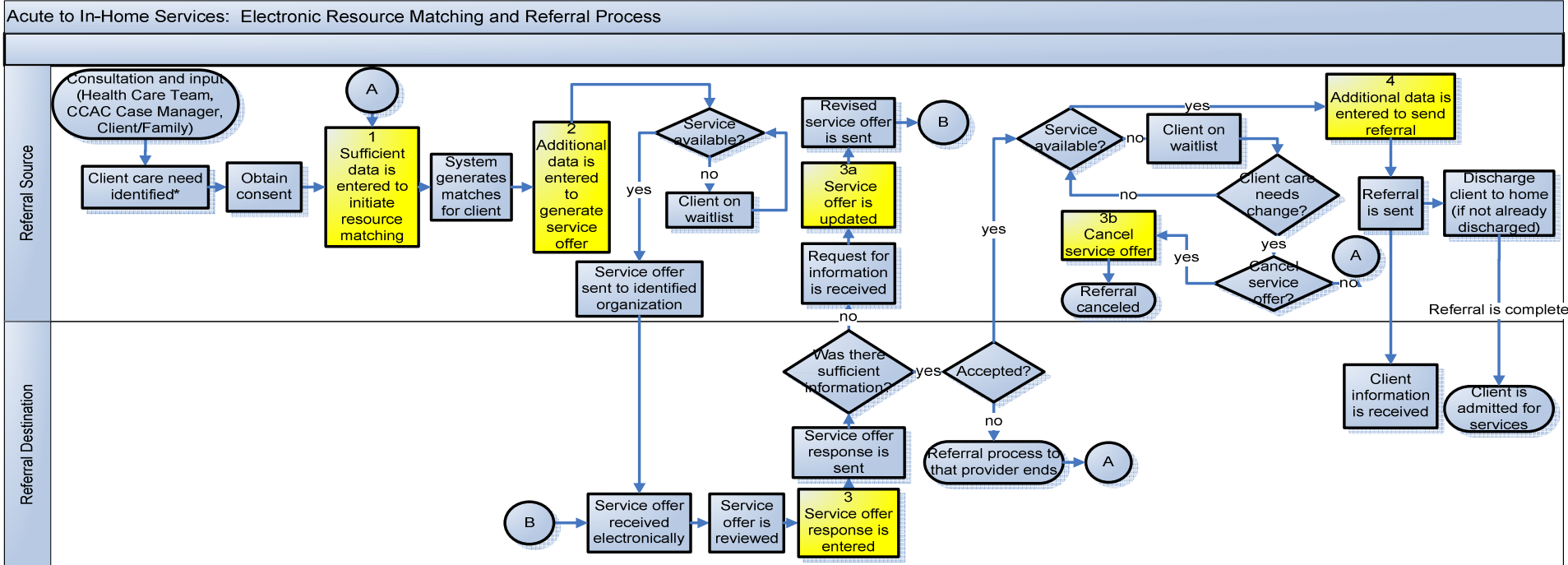
- **Time Frames**

- Referral is sent from acute setting/CCAC case manager once need is identified, but at least one to two days ahead of anticipated discharge.
- Receiving providers to respond according to contract schedules.

- **Differences from other process flows**

- In-Home Services process flow terminology includes a service offer before the referral is sent.
- In-Home Services process flow includes an additional waitlist opportunity before a service offer is sent (e.g., based on funded services).
- Minimal information, with no identifying information, is sent with the service offer; the bulk of the patient information is sent with the referral.

Acute to In-Home Services Business Process Flow



Legend

Yellow boxes indicate information gathering points

- * CCAC Case Manager is notified of the potential referral by health care team and manages the referral.
- 1 – Resource Matching - Submit sufficient information to initiate resource matching to identify potential providers
- 2 – Service Offer – Service offer is initiated using required information.
- 3 – Service offer response – Referral destination enters the service offer response.
 - 3a – Missing or supplemental information required
 - 3b – Referral cancellation
- 4 – Referral Information – Balance of information needed for referral is entered.



In-Home Services: Referral Resource Matching

Information Gathering Point 1

Working Definition for Resource Matching: The process of using the RM&R solution to query a directory of facilities, programs and services that may meet the patient's needs within the identified LOC.

Question: What is the minimum information required to perform the Resource Matching process?

Category	Data Element	Description & Examples
Referral Information	Referral Type	The referral destination type (e.g. Acute to In-Home services)
	Requested Service or Program	A specific program/service that the patient requires. (e.g. nursing, personal support (help with bathing, dressing, etc.), physiotherapy, occupational therapy, speech-language therapy, social work, nutritional counseling, medical supplies and equipment, other)
	Additional Service Information / Special Needs	Additional information about the service that the patient requires (e.g. equipment description, other)
	Age	The patient's age which is used to determine service / program eligibility
	Treatment Location Postal Code	The geographic area where the client would prefer the service to take place
	Gender	The sex of the patient

In-Home Services: Service Offer

Information Gathering Point 2 (1 of 2)

Working Definition for Service Offer: This information allows a facility or organization to determine whether they can provide the required service.

Question: What is the minimum information required to initiate a service offer?

Category	Data Element	Description & Examples
Referral Information	Resource Matching Data Elements	Appropriate data elements from the resource matching step including referral type, program/service, additional service information, date of birth, treatment location postal code, gender
	Treatment Address and Postal Code	The location where service to be provided (either the patient residence or the location where the provider will offer the service)
	Service Requested Start Date	The expected date In-Home services should start
	Expected Length of Service	The expected length of service
	Referral Create Date	The date that the referral is created
	Referral Send Date	The date the referral is sent
	Referring Facility	The acute facility where the referral originates
	Referral Completed by Person	Contact information of the person that created the referral (e.g. name, phone)
	Reason for Referral	Reason for referral (e.g. regular caregiver is going on vacation)
Patient Information	Postal Code	The patients postal code. Only the patient's postal code is captured at this time

Acute to In-Home Services: Service Offer Information Gathering Point 2 (2 of 2)

Working Definition for Service Offer: This information allows a facility or organization to determine whether they can provide the required service.

Question: What is the minimum information required to initiate a service offer?

Category	Data Element	Description & Examples
Observations and Finding	Diagnosis	A diagnosis of the patient's condition

Acute to In-Home Services: Service Offer Response

Information Gathering Point 3

Working Definition for Service Offer Response: The process of accepting or declining a service offer.

Question: What is the minimum information required to respond to a service offer?

Category	Data Element	Description & Examples
Service Offer Information	Service Offer Response	The response to the service offer request from the service provider (e.g. Accepted, Accepted Waitlist, Declined, Send-back)
	Offer Response Date	The date and time the service offer is accepted or declined. This is a solution generated date for KPI purposes
	Estimated Date of Service	The estimated date that the requested service should start
	Provided Decline Reason	The reason for declining a service offer, if the offer is declined
	Notes	A note field to capture the following: if the service offer is “Declined”, additional information to explain reason for decline. If service offer is a “Send-back”, a note that indicates what information is missing

Acute to In-Home Services: Send Back Information Gathering Point 3a

Working Definition for Send Back: The process of providing additional or missing information that is required to make a service offer accept or decline decision.

Question: What is the missing or additional information required to complete the request in the notes field of the Service Offer Response?

Category	Data Element	Description & Examples
Service Offer Information	Additional or Missing information	Any information that was required but not provided in information gathering step 2

Acute to In-Home Services: Cancel Service Offer

Information Gathering Point 3b

Working Definition for Cancel Service Offer: The process of cancelling a service offer because the patient's care requirements have changed such that the initial service offer is no longer appropriate.

Question: What is the minimum information required to cancel a service offer?

Category	Data Element	Description & Examples
Service Offer Information	Service Offer Cancel	An indication that the service offer is cancelled
	Service Offer Cancel Date	The date the service offer is cancelled
	Provided Cancel Reason	The reason that the service offer is cancelled (e.g. patient is deceased)

Acute to In-Home Services: Referral Completion

Information Gathering Point 4 (1 of 2)

Working Definition for Referral Completion: This information is required to complete a referral.

Question: What is the minimum information required to complete a referral?

Category	Data Element	Description & Examples
Referral Information	Resource Matching Data Elements	Appropriate data elements from the resource matching step including referral type, program/service, additional service information, date of birth, treatment location postal code, gender
Referral Information	Referral Date	The date the transfer information is added to the referral
Patient Information	Patient Identifier	OHIP number or other provincial health number. Note: other patient information (e.g. name, phone, address, language) is expected to come from interface with ADT system
Emergency Contact Information	Non-patient Contact Information	Contact information for relatives of the patient. (e.g. name, phone; relationship to patient - e.g. substitute decision maker, power of attorney; public guardian & trustee)
Physician Information	Physician ID / OHIP Billing Number Physician Type	Physician information and type (e.g. attending, referring, family)
Other Practitioners	Other Practitioners Information	Contact information for other practitioners involved in the referral (e.g. case manager, nurse, therapists, other)
Finance Information	Payment Type and Insurance Information	The method that will be used to pay for the LTC service (e.g. OHIP, WSIB, insurance, self) If the payment is via insurance, the additional insurance information that is required (e.g. company, policy no., group no.)

Acute to In-Home Services: Referral Completion

Information Gathering Point 4 (2 of 2)

Working Definition for Referral Completion: This information is required to complete a referral.

Question: What is the minimum information required to complete a referral?

Category	Data Element	Description & Examples
Medical Orders	Medical Orders	Note: expectation is that medical orders will be an attachment to the referral or faxed to the referral destination
Consent	Consent	Consent to the referral, consent to the use of referral information
Discharge Information	Behaviours, concerns, issues and risks	A indication of what behaviours, concerns, issues and risks that may impact the ability to receive rehab.
	Discharge Instructions Medication Administration list Discharge Medication list Equipment and Supplies	Additional information about the patient for discharge purposes

Referral Statuses

Referrals may pass through a number of statuses which identify progress through the referral life cycle. Statuses are defined by the stage in the business process. Recommended statuses have been identified by the Business Process and Data Elements Sub-group and are provided as a guide to LHINs as they develop statuses in their own RM&R solution.

Example of referral status changes:

Submitted → New → In Progress → Accepted – Bed Available → Complete

Referral Statuses

Status	Definition
Incomplete	The sending organization has created a referral and saved it, but has not yet submitted it to any recipient organization(s)
Submitted	The sending organization has completed and sent the referral to one or more recipient organizations
New	The recipient organization(s) has received a new referral
In Process	The recipient organization is working on the referral
Send-back	The recipient organization is requesting additional information about the referral in order to complete referral processing
Accepted-Bed available	A recipient organization has received a referral and responded by accepting the referral
Accepted-Conditionally	A recipient organization has received a referral and responded by accepting the referral if an identified condition is met
Declined	A recipient organization has declined the referral
Accepted-Waitlist	A recipient organization has accepted and the client has been offered a wait list placement
Revised	The sending organization has updated the referral information or selected to terminate an “On Hold” status
On Hold	The sending organization has temporarily suspended action on the referral
Cancelled	The sending organization has cancelled a referral due to a change in client needs
Deleted	The sending organization has deleted a referral created in error
Complete	The client has been accepted to a provider facility and discharged from the source facility

Functional Requirements Overview

The functional requirements define the application functionality needed to execute the business processes.

Context

- The functional requirements include functional areas, specific requirements and recommendations.
- The requirements and corresponding recommendations were developed and approved by the Business Process and Data Elements Sub-group in consideration of leading practices and the business processes designed by the sub-group and illustrated in this document.
- These requirements provide a starting point when LHINs begin their own requirements gathering process.
- LHINs can review and decide which requirements are necessary to meet their business needs and add any that may be missing. Inclusion of any of these requirements in the RM&R solution is at the discretion of the LHIN or LHIN cluster.

Functional Areas

The functional requirements are grouped into functional areas described on this page with specific requirements on the following pages.

Number	Requirement Area	Description
1	General	<ul style="list-style-type: none"> General system functionality
2	Referral Origination and Routing	<ul style="list-style-type: none"> How referrals are initiated and move along pathways
3	Referral Owner	<ul style="list-style-type: none"> Identification and maintenance of a referral owner
4	Delivery Mechanisms	<ul style="list-style-type: none"> The various ways a referral or notification can be delivered
5	Support for Referral Business Processes	<ul style="list-style-type: none"> Includes printing, setting tolerances for alerts, and assigning priorities to referrals
6	Resource Matching	<ul style="list-style-type: none"> Identification of service providers based on client's needs and/or preferences
7	Catalogues	<ul style="list-style-type: none"> Information about services available from each provider
8	Referral Information	<ul style="list-style-type: none"> Ability to capture and relay required information in the referral
9	Attachments	<ul style="list-style-type: none"> Management of attachments to referral
10	Transparency	<ul style="list-style-type: none"> Ability to view historical elements of a referral
11	Waitlist	<ul style="list-style-type: none"> Maintenance of waitlists
12	Auditing	<ul style="list-style-type: none"> Time stamping and user history
13	Online Help	<ul style="list-style-type: none"> Help features
14	Reporting	<ul style="list-style-type: none"> Reporting capabilities

Functional Requirements (1 of 6)

Number	Functional Area	Description	Recommendation
1.1	General	<ul style="list-style-type: none"> ▪ Navigation - Ability for the user to retrieve client records, save work in progress and return to home page 	<ul style="list-style-type: none"> ▪ Highly recommended
1.2	General	<ul style="list-style-type: none"> ▪ Search - Ability to search for a referral or a client 	<ul style="list-style-type: none"> ▪ Highly recommended
1.3	General	<ul style="list-style-type: none"> ▪ Drop-Down Menus - Ability to have drop down menus, where appropriate, to limit the amount of free text to input 	<ul style="list-style-type: none"> ▪ Highly recommended
1.4	General	<ul style="list-style-type: none"> ▪ Systems Integration - Ability to interface with hospital or clinical information systems and CCAC information systems 	<ul style="list-style-type: none"> ▪ Highly recommended
2.1	Referral Origination and Routing	<ul style="list-style-type: none"> ▪ Provider to Provider - Ability to send a referral between provider organizations 	<ul style="list-style-type: none"> ▪ Highly recommended
2.2	Referral Origination and Routing	<ul style="list-style-type: none"> ▪ Program to Program - Ability to send a referral between programs in the same organization including inpatient to outpatient referrals 	<ul style="list-style-type: none"> ▪ Highly recommended
2.3	Referral Origination and Routing	<ul style="list-style-type: none"> ▪ Site to Site - Ability to send a referral from one site to another site in the same organization 	<ul style="list-style-type: none"> ▪ Highly recommended
2.4	Referral Origination and Routing	<ul style="list-style-type: none"> ▪ Department to Department - Ability to send a referral from one department to another within the same organization and location 	<ul style="list-style-type: none"> ▪ Highly recommended
2.5	Referral Origination and Routing	<ul style="list-style-type: none"> ▪ Forwarding - Ability for sending organization to forward on a declined referral to another organization 	<ul style="list-style-type: none"> ▪ Nice to have
2.6	Referral Origination and Routing	<ul style="list-style-type: none"> ▪ Duplicate Referrals - Ability to alert the user if a duplicate referral for the same care types has been created 	<ul style="list-style-type: none"> ▪ Highly recommended
2.7	Referral Origination and Routing	<ul style="list-style-type: none"> ▪ Multiple Recipients with One Referral - Ability to send a single referral to multiple recipients 	<ul style="list-style-type: none"> ▪ Highly recommended

Functional Requirements (2 of 6)

Number	Functional Area	Description	Recommendation
2.8	Referral Origination and Routing	<ul style="list-style-type: none"> ▪ Copy Referral - Ability to send a copy of a referral to another provider for information purposes 	<ul style="list-style-type: none"> ▪ Highly recommended
3.1	Referral Owner	<ul style="list-style-type: none"> ▪ Ownership - Ability to denote a referral as belonging to an individual or unit 	<ul style="list-style-type: none"> ▪ Highly recommended
3.2	Referral Owner	<ul style="list-style-type: none"> ▪ Contribution to a Referral - Ability of other health care team members to contribute to the referral 	<ul style="list-style-type: none"> ▪ Highly recommended
3.3	Referral Owner	<ul style="list-style-type: none"> ▪ Ownership transfer - Ability to transfer ownership of a referral between individuals or units 	<ul style="list-style-type: none"> ▪ Nice to have
4.1	Delivery Mechanisms	<ul style="list-style-type: none"> ▪ Auto-fax - Automatically fax referral to recipient organization if the recipient organization cannot receive referrals electronically 	<ul style="list-style-type: none"> ▪ Highly recommended
4.2	Delivery Mechanisms	<ul style="list-style-type: none"> ▪ Email Notification - Notification of referral receipt through email notification 	<ul style="list-style-type: none"> ▪ Highly recommended
4.3	Delivery Mechanisms	<ul style="list-style-type: none"> ▪ Mobile Device Notification - Ability to receive and action a referral from a mobile device such as a PDA or Blackberry 	<ul style="list-style-type: none"> ▪ Highly recommended
4.4	Delivery Mechanisms	<ul style="list-style-type: none"> ▪ Tablet or Notebook - Ability to receive and action a referral from a notebook or mobile computer equipped with a touch screen or graphics technology and stylus 	<ul style="list-style-type: none"> ▪ Highly recommended
5.1	Support for Referral Business Processes	<ul style="list-style-type: none"> ▪ Referral Statuses and Transitions - Support referral business process and workflow by supporting business logic, multiple statuses for a referral and status transitions 	<ul style="list-style-type: none"> ▪ Highly recommended

Functional Requirements (3 of 6)

Number	Functional Area	Description	Recommendation
5.2	Support for Referral Business Processes	<ul style="list-style-type: none"> ▪ Print Referral or Resource Match - Ability to print a referral or resource match 	<ul style="list-style-type: none"> ▪ Highly recommended
5.3	Support for Referral Business Processes	<ul style="list-style-type: none"> ▪ Referral Priority Category - Ability to specify priority category for a LTC referral (e.g. 1A, 1A1, 1B, 2, 3) 	<ul style="list-style-type: none"> ▪ Highly recommended
5.4	Support for Referral Business Processes	<ul style="list-style-type: none"> ▪ Tracking and Alerting on Timeframes for Referral States - Defines the maximum time period that a referral can remain in a specific status before an alert is issued 	<ul style="list-style-type: none"> ▪ Highly recommended
5.5	Support for Referral Business Processes	<ul style="list-style-type: none"> ▪ Communication of bed availability - Ability to communicate bed availability to a sending organization 	<ul style="list-style-type: none"> ▪ Nice to have
5.6	Support for Referral Business Processes	<ul style="list-style-type: none"> ▪ Communication of Questions and Requests for Information - Ability of user to request more information 	<ul style="list-style-type: none"> ▪ Highly recommended
5.7	Support for Referral Business Processes	<ul style="list-style-type: none"> ▪ Update Referral Information - Ability of user to update information in a submitted or received referral 	<ul style="list-style-type: none"> ▪ Highly recommended
5.8	Support for Referral Business Processes	<ul style="list-style-type: none"> ▪ Confirmation of Referral Receipt - Ability of user to confirm receipt of a referral 	<ul style="list-style-type: none"> ▪ Nice to have

Functional Requirements (4 of 6)

Number	Functional Area	Description	Recommendation
5.9	Support for Referral Business Processes	<ul style="list-style-type: none"> ▪ Communication of Client Acceptance to Alternate Providers - Ability to communicate that client was discharged or transferred to a facility and the other referrals are either cancelled or remain open for a period of time 	▪ Highly recommended
6.1	Resource Matching	<ul style="list-style-type: none"> ▪ Viewing Criteria - View criteria for eligibility for a program 	▪ Highly recommended
6.2	Resource Matching	<ul style="list-style-type: none"> ▪ View List of Available Providers - View list of providers that are currently available and their services/attributes 	▪ Highly recommended
6.3	Resource Matching	<ul style="list-style-type: none"> ▪ Automated Matching of Referral Against Available Providers Meeting Criteria - Match a client to an available provider using the criteria for acceptance to a program 	▪ Highly recommended
6.4	Resource Matching	<ul style="list-style-type: none"> ▪ Override a Match - Ability of a user to decline a client match 	▪ Highly recommended
6.5	Resource Matching	<ul style="list-style-type: none"> ▪ Bed Matching - Ability to match a client to a bed 	▪ Highly recommended
7.1	Catalogues	<ul style="list-style-type: none"> ▪ Provider Services - Catalogue of services available by provider to assist in finding services and providers when making a referral 	▪ Highly recommended
8.1	Referral Information	<ul style="list-style-type: none"> ▪ Client, Referrer, Practitioner Information and Reason for Referral - Client demographics, those contributing to the referral and reason for referral are all available 	▪ Highly recommended
8.2	Referral Information	<ul style="list-style-type: none"> ▪ Medical, Social History and Clinical Information – Availability of client history through systems integration 	▪ Highly recommended
8.3	Referral Information	<ul style="list-style-type: none"> ▪ Clinical Notes - Clinical information provided by referral source in free text 	▪ Highly recommended

Functional Requirements (5 of 6)

Number	Functional Area	Description	Recommendation
8.4	Referral Information	<ul style="list-style-type: none"> ▪ Complete Information in a Referral - Ability to alert the user that information in a referral is not complete 	<ul style="list-style-type: none"> ▪ Highly recommended
8.5	Referral Information	<ul style="list-style-type: none"> ▪ Identify Required Information - Ability to denote information as required or optional 	<ul style="list-style-type: none"> ▪ Highly recommended
8.6	Referral Information	<ul style="list-style-type: none"> ▪ Referral Information Recall - Ability to recall information from a prior referral for service and pre-populate new referrals with user verification of information 	<ul style="list-style-type: none"> ▪ Highly recommended
9.1	Attachments	<ul style="list-style-type: none"> ▪ Attachments of Varying Types - Ability to add attachments of various types to a referral, such as clinical notes and images 	<ul style="list-style-type: none"> ▪ Highly recommended
9.2	Attachments	<ul style="list-style-type: none"> ▪ Cataloguing, Archiving, Retrieving or Otherwise Storing Attachments - Ability to store, index, search, access and retrieve individual attachments from a referral 	<ul style="list-style-type: none"> ▪ Nice to have
10.1	Transparency	<ul style="list-style-type: none"> ▪ Referral Status - Ability to view or query status of referral or referrals 	<ul style="list-style-type: none"> ▪ Highly recommended
10.2	Transparency	<ul style="list-style-type: none"> ▪ Bed Availability - Ability to view comprehensive bed availability across providers 	<ul style="list-style-type: none"> ▪ Nice to have
10.3	Transparency	<ul style="list-style-type: none"> ▪ Removal of Referral Information - Ability to hide client information from a receiving provider after a referral has been declined, cancelled or deleted 	<ul style="list-style-type: none"> ▪ Highly recommended
11.1	Waitlist	<ul style="list-style-type: none"> ▪ View Existing Waitlist Information - Ability to sending organization to view waitlist information by provider, CCAC or service when making a referral 	<ul style="list-style-type: none"> ▪ Nice to have

Functional Requirements (6 of 6)

Number	Functional Area	Description	Recommendation
11.2	Waitlist	<ul style="list-style-type: none"> ▪ Update Waitlist Information - Ability to update waitlist when making referrals to a provider 	<ul style="list-style-type: none"> ▪ Nice to have
11.3	Waitlist	<ul style="list-style-type: none"> ▪ Track Multiple Waitlists - Ability to track multiple program waitlists for a facility 	<ul style="list-style-type: none"> ▪ Highly recommended
11.4	Waitlist	<ul style="list-style-type: none"> ▪ Anticipated Wait Times - Ability to track and share anticipated wait times for a provider or a bed 	<ul style="list-style-type: none"> ▪ Nice to have
12.1	Auditing	<ul style="list-style-type: none"> ▪ Log User and System Access - Ability to log user and system access to referral information for the purposes of maintaining audit logs 	<ul style="list-style-type: none"> ▪ Highly recommended
13.1	Online Help	<ul style="list-style-type: none"> ▪ Access to an Online Help Feature - Ability to access online help within the application 	<ul style="list-style-type: none"> ▪ Highly recommended
14.1	Reporting	<ul style="list-style-type: none"> ▪ Generate Reports - Ability to generate reports 	<ul style="list-style-type: none"> ▪ Highly recommended
14.2	Reporting	<ul style="list-style-type: none"> ▪ Save Reports - Ability to save generated reports 	<ul style="list-style-type: none"> ▪ Highly recommended
14.3	Reporting	<ul style="list-style-type: none"> ▪ Create Custom Reports - Ability to create custom reports 	<ul style="list-style-type: none"> ▪ Highly recommended
14.4	Reporting	<ul style="list-style-type: none"> ▪ Export Reports - Ability to export reports 	<ul style="list-style-type: none"> ▪ Highly recommended

Glossary of Terms (1 of 4)

The Glossary of Terms provides meaning for terminology in the PRM and includes sources for definitions where applicable

Term	Definition
Admission Criteria	<ul style="list-style-type: none"> ▪ Clinical evidence-based criteria utilized by a professional to identify and determine the eligibility of a patient to be admitted to the institution based on appropriateness of health services required
Acceptance of Referral	<ul style="list-style-type: none"> ▪ An institution (destination provider) accepts a referred patient for initiation of service and/or admission to the facility
Alternate Level of Care (ALC)	<ul style="list-style-type: none"> ▪ When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his delegate ▪ The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies) <p>Source: Cancer Care Ontario website: http://www.cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=43214</p>
Community Care Access Centre (CCAC) Case Management	<ul style="list-style-type: none"> ▪ CCAC is vested in case managers who must assess and review requirements, determine eligibility, and develop and evaluate the plans of service for CCAC services and authorize the expenditures of funds for services <p>Source: MOHLTC website: http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac_6.pdf</p>

Glossary of Terms (2 of 4)

Term	Definition
Client Health and Registry Information System (CHRIS)	<ul style="list-style-type: none"> CHRIS is a comprehensive clinical case management system within the CCACs delivering a common set of functions related to Case Management, Care Planning, Placement, and Billing. A web based application that facilitates access from multiple locations over the internet; providing key functions supporting intake and referral, service planning and authorization, service matching and scheduling through an automated provider offer and response algorithm and electronic referrals, ordering of equipment and supplies, long-term placement and waitlist choice management, and short-term bookings. CHRIS contains approximately 65 canned reports and is ODB compliant, notifying pharmacies of adds, extensions, renewals, and ends. CHRIS is EMPI ready based on a single data repository, fully MIS compliant for the Ministry of Health Financial and Statistical Reporting. <i>Source: OACCAC Information Systems, CHRIS Business Analyst</i>
Complex Continuing Care (CCC)	<ul style="list-style-type: none"> Complex continuing care is a specialized program of care providing programs for medically complex patients whose condition requires a hospital stay, regular on-site physician care and assessment, and active care management by specialized staff <i>Source: http://www.oha.com/CurrentIssues/Issues/eHealth/Documents/Optimizing_the_Role_of_CCCandRehab.pdf</i>
Convalescent Care Program	<ul style="list-style-type: none"> Convalescent Care Program provides Long-Term Care (LTC) beds for patient who require convalescent care for stays of less than 90 days. The program will help patients recover their strength, endurance and functioning after discharge from hospital and before returning home <i>Source: http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm_sec_11/11-10.html</i>
Denial of Referral	<ul style="list-style-type: none"> An institution (destination provider) denies a referred patient from admission to the facility
Discharge Criteria	<ul style="list-style-type: none"> Clinical evidence-based criteria utilized by a professional to identify and determine the patient is appropriate to be discharged from the institution based on the current condition and no longer requires the services of care at the current Level of Care (LOC) and is ready to transition to a destination with a lower LOC

Glossary of Terms (3 of 4)

Term	Definition
Discharge Planners	<ul style="list-style-type: none"> Qualified health care professionals who ensure the consistent application of the discharge planning process including the early needs identification, assessment, and goal setting. Furthermore discharge planners have an integral part in the planning, implementation, coordination and evaluation of client's and families' care needs <p>Source: http://www.adpco.ca/newsfiles/Position%20Statement.pdf</p>
eReferral	<ul style="list-style-type: none"> A referral made electronically to direct a patient from a source caregiver to a target caregiver (health professional or institution), recommending the type and level of care required by the patient in a secure and efficient manner
Home	<ul style="list-style-type: none"> A destination where a patient resides after discharge from an institution and may receive family support, In-Home services and/or structural changes
Home with CCAC	<ul style="list-style-type: none"> A destination where a patient resides after discharge from an institution and receives services through the coordination of CCAC (e.g. assistance from personal support workers)
Level of Care	<ul style="list-style-type: none"> A series of broad categories of services of care provided to patients with different needs, ranging from low to high intensity
Long-Term Care (LTC)	<ul style="list-style-type: none"> A Long-Term Care (LTC) home provides care and services for people who no longer are able to live independently or who require onsite nursing care, 24-hour supervision or personal support. Nursing homes under the <i>Nursing Homes Act</i>, approved charitable homes for the aged under the <i>Charitable Institutions Act</i> and homes under the <i>Homes for the Aged and Rest Homes Act</i> are all LTC homes <p>Source: MOHLTC website: http://www.health.gov.on.ca/english/public/program/ltc/28_pr_glossary.html</p>

Glossary of Terms (4 of 4)

Term	Definition
Palliative Care	<ul style="list-style-type: none"> Services provided to patient's and their significant others with life-limiting, chronic or terminal illness. The goal is to provide pain and symptom management and/or quality end-of-life care which is delivered by the inter-professional team
Pathway	<ul style="list-style-type: none"> A specific route a referral may take between service providers
Referral Event	<ul style="list-style-type: none"> An action on a referral, triggered by a user (examples include sending a referral, revising a referral, responding to a referral)
Referral Life Cycle	<ul style="list-style-type: none"> The collection of states and transitions that referrals pass through from inception to completion
Referral State	<ul style="list-style-type: none"> Condition of a referral at a certain point in the referral life cycle, may also be referred to as a status
Referral Transition	<ul style="list-style-type: none"> The transformation from one referral state to another, triggered by a referral event
Rehabilitation Services	<ul style="list-style-type: none"> Services provided to patients who had an illness or injury and are in the process of restoring skills to regain maximum self-sufficiency and function in normal or as near normal manner; services may include physiotherapy, occupational therapy, speech-language pathology therapy, and recreational therapy
Resource Matching	<ul style="list-style-type: none"> The process of using the RM&R solution to query a directory of facilities, programs and services that may meet the patient's needs within the identified LOC

Opportunities and Recommendations (Page 1 of 2)

The following opportunities relative to the desired future state of Business Process and Data Elements vision have been identified, along with suggested recommendations and next steps. Next steps are dependent on further consultation with the relevant stakeholders and sponsor organizations.

Opportunity	Recommendation	Next Steps
<ul style="list-style-type: none"> ▪ Inconsistency in how ALC determination is completed at hospitals, with variation in practice of utilizing evidence-based criteria, resulting in potential underreporting of ALC days and inappropriate LOC determination for post-acute options 	<ul style="list-style-type: none"> ▪ Develop a Provincial Care Management Model that includes initial and concurrent evidence-based criteria review as the next phase of the ALC Definition. ▪ Adopt and recommend a provincial implementation of initial and concurrent clinical review utilizing evidence-based criteria to identify appropriate LOC and ALC determination 	<ul style="list-style-type: none"> ▪ ATC Information Program should develop a Provincial Care Management Model to support the next phase of the ALC Definition ▪ ATC Information Program should evaluate the potential options for vendors and tools for evidence-based criteria and develop a recommendation ▪ ATC Information Program to support the implementation of the provincial Care Management Model
<ul style="list-style-type: none"> ▪ Inconsistent practice of the first bed available policy and how this will impact the ALC day indicators (e.g., higher for hospitals that don't enforce the policy) 	<ul style="list-style-type: none"> ▪ Identify the hospitals that enforce the policy and monitor the impact on the ALC metrics 	<ul style="list-style-type: none"> ▪ ATC Information Program to monitor the impact of the policy ▪ ATC Information Program to work with the Ministry to develop recommendations

Opportunities and Recommendations (Page 2 of 2)

The following opportunities relative to the desired future state of Business Process and Data Elements vision have been identified, along with suggested recommendations and next steps. Next steps are dependent on further consultation with the relevant stakeholders and sponsor organizations.

Opportunity	Recommendation	Next Steps
<ul style="list-style-type: none"> ▪ Impact of utilizing transitional care beds to increase access to care and how will these patient days impact ALC (e.g., will they be considered ALC for acute care) 	<ul style="list-style-type: none"> ▪ Define the LOC for the transitional care beds utilizing evidence-based criteria ▪ Identify based on the LOC defined if the patient will be classified as ALC 	<ul style="list-style-type: none"> ▪ The ALC Definition Group to work with the Ministry to define the provincial transitional care beds LOC ▪ Identify any implications for implementation of LHIN-based RM&R solutions
<ul style="list-style-type: none"> ▪ Lack of integration of CHRIS across the CCACs and manual input of all the referrals in CHRIS, resulting in rework and potential errors and omissions 	<ul style="list-style-type: none"> ▪ As part of the RM&R solution implementation, LHINs should develop recommendations regarding integration with CHRIS and the RM&R solution 	<ul style="list-style-type: none"> ▪ The LHINs, the OACCAC and eHealth Ontario to explore opportunities for CHRIS integration at a provincial level and the feasibility of developing a common interface to CHRIS for the purposes of RM&R

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Appendix 1: Sub-group Terms of Reference

- **Purpose**

- This sub-group was established to **provide content expertise for the PRM in the area of business requirements and guidelines and data elements.**

- **Objectives**

- Provide detailed content expertise or knowledge on business requirements and guidelines and data elements
- Share information on the present state and identify potential implications for the PRM
- Where applicable, share information on existing implementations and lessons learned
- Identify issues, risks and barriers for the projects
- Inform the Provincial Reference Model deliverables
- Facilitate opportunities for information sharing and collaboration across organizations and sectors
- Contain significant geographic representation and significant representation of health service providers

- **Member Responsibilities**

- Represent, engage and follow up with their respective organizations and sectors for contribution to applicable work streams
- Contribute content expertise or knowledge
- Review materials and participate in group discussions during meetings
- Act as a point of communication for their respective organization, LHIN or sector
- Obtain input from key stakeholders within their jurisdictions to further inform the deliverables (e.g. input from service providers)

- **Committee Structure**

- Meetings were held via teleconferencing.
- Secretariat support was provided by the ALC RM&R project team.
- Committee members were permitted to send a delegate on their behalf when required.
- Agenda and meeting materials were issued at minimum, three business days prior to meetings.
- Committee membership participation was required from July 2009 to October 2009 for approximately 3-5 meetings, each being approximately three hours in length.

Appendix 1: Sub-group Activities

Objective

- The sub-group provided input to and validation of deliverables developed as part of the business process and data elements components of the PRM.

In-Scope Pathways

- Acute to Rehab
- Acute to CCC
- Acute to LTC
- Acute to In-Home Services

Activities

- The sub-group validated the following:
 - Business processes
 - Assumptions
 - Business requirements (functional requirements)
 - Key timeframes
 - Minimum data sets – for the referrals for the sectors
 - States and statuses
 - Glossary of terms

Out-of-Scope

- Details of data sets (e.g. field type, field size, valid entries)

Appendix 1: Sub-group Engagement Approach and Meetings

- Orientation to the sub-group ,and work and approach – two-hour meeting, July 29, 1-3 pm
- The sub-group membership was then divided into 2 groups; one for referrals to rehab or CCC and one for referrals to LTC or In-Home Services
- The sub-group meetings were arranged in groups as follows:

	Group 1: Acute to Rehab or CCC	Group 2: Acute to LTC or In-Home with Services (CCAC)
Meeting 1	August 18 9 a.m.- 12 p.m.	August 19 9 a.m. - 12 p.m.
Meeting 2	September 9 9 a.m. - 12 p.m.	September 10 9 a.m. - 12 p.m.

- Materials were distributed 3 business days in advance of meetings, and consisted of straw models (e.g., process flows, data sets and functional requirements)
- In advance of meetings, sub-group members were responsible for:
 - Reviewing all distributed materials and noting comments to be raised during the meeting
 - Soliciting additional expertise where needed, as determined by the sub-group member
- Following meetings, sub-group members were responsible for:
 - Additional reviews as necessary, as determined during sub-group meetings
- Discussions focused on validating high-level process, business requirements, data elements, key time frames, states and statuses and definitions

Appendix 1: Sub-group Pathway-specific meetings

- Following the orientation meeting, the membership was divided into two groups and each had a pathway focus (those that include the CCAC and those that do not)
- There were two three-hour calls per group
- Meetings were conducted by conference call
- The focus was on identifying a future state for electronic referrals from acute care to rehab or CCC and through the CCAC to LTC or In-Home with Services
- In the initial pathway-specific meetings, review of high-level business process was followed by the key requirements and data elements
- Following completion of the initial pathway specific meetings:
 - Material was updated by the project team based on the recommendations of the group
 - Sub-group members acted on any homework assigned (e.g., consulted with experts or gathered information)
- In the final pathway-specific meetings, updated content was presented and material validated by the group

Appendix 1: Sub-group Membership Summary

Sub-group	Expertise of Members	Roles of Members
<p>Business Requirements and Guidelines & Data Elements Work</p>	<ul style="list-style-type: none"> ▪ Plan and manage programs and resources ▪ Determine appropriate level of care and do resource matching ▪ Coordinate and make referrals ▪ Receive and make decisions about incoming referrals ▪ Manage process improvement initiatives and projects ▪ Plan and manage patient care 	<ul style="list-style-type: none"> ▪ Client Services Manager ▪ Social Worker ▪ Program Director Acute Care/Transitional Care ▪ ED/ALC Performance Coordinator ▪ Senior Manager - Client Services ▪ AVP Clinical Appropriateness and Efficiency, Quality of Care, Patient Safety & Pharmacy ▪ Manager of Case Managers ▪ LHIN Coordinator ▪ Business Lead, IR & ER/ALC, OACCAC Business Solutions and IM ▪ E-Referral Project Lead/Senior Program Manager ▪ Administrator – LTC Home ▪ Senior Integration Consultant ▪ eHealth LHIN Lead & Regional CIO Health Care Network of Southeastern Ontario ▪ Senior Director, Client Services ▪ Clinical Director, Rehabilitation Services Program

Appendix 1: Sub-group Members (1 of 4)

Member	Role/Title	Organization	Email	Pathway Alignment
Jennifer Scott	Director, Placement Services	CCAC	jennifer.scott@central.ccac-ont.ca	Acute to LTC and In-Home Services
Navaz Gangji	Social Worker	North York General Hospital	Navaz.Gangji@nygh.on.ca	Acute to LTC and In-Home Services
Lucia Cook	Manager, Complex Medical Rehab, Palliative Care and Patient Flow Navigator	Southlake Regional Health Centre	lcook@southlakeregional.org	Acute to LTC and In-Home Services
Jean Kish	Program Director Acute Care/Transitional Care	CCAC	Jean.Kish@ce.ccac-ont.ca	Acute to LTC and In-Home Services
Andrew Ward	Senior Manager - Client Services	CCAC	andrew.ward@esc.ccac-ont.ca	Acute to LTC and In-Home Services
Sherry Parsley	Director, Client Services	CCAC	sherry.parsley@hnhb.ccac-ont.ca	Acute to LTC and In-Home Services
Nancy Kula	Senior Director, Client Services	CCAC	nancy.kula@mh.ccac-ont.ca	Acute to LTC and In-Home Services
Carolyn McLeod	Administrator	Long-Term Care Home	cmcleod@jarlette.com	Acute to LTC and In-Home Services
Mark Walden	Senior Director, Strategic Planning and Integration	CCAC	mark.walden@se.ccac-ont.ca	Acute to LTC and In-Home Services
Donna Ladouceur	Senior Director, Client Services	CCAC	donna.ladouceur@sw.ccac-ont.ca	Acute to LTC and In-Home Services
Joanne Greco	Director of Short Stay & Operations	CCAC	Joanne.Greco@toronto.ccac-ont.ca	Acute to LTC and In-Home Services
Melissa Coulson	Implementation Lead	SIMS	Melissa.coulson@uhn.on.ca	Acute to LTC and In-Home Services

Appendix 1: Sub-group Members (2 of 4)

Member	Role/Title	Organization	Email	Pathway Alignment
Jane Casey	Director, Medicine, Complex Medical Rehab, Inpatient Cancer, Rehab & Chronic Diseases	Southlake Regional Health Centre	JCasey@southlakeregional.org	Acute to LTC and In-Home Services
Catherine Arges	Social Worker	North York General Hospital	Catherine.Arges@nygh.on.ca	Acute to Rehab or CCC
Helen Zipes	Clinical Director, Rehabilitation Services Program	TOH/TRC	hzipes@toh.on.ca	Acute to Rehab or CCC
Vicki Rozon	Director, Operations	Bruyere Continuing Care	vrozon@bruyere.org	Acute to Rehab or CCC
Carol Murphy	ED-ALC Performance Lead Coordinator	LHIN	Carol.Murphy@LHINS.ON.CA	Acute to Rehab or CCC
Jennifer Kodis	Director, Rehabilitation/Seniors Health Program, Hamilton Health Sciences	St. Peter's Hospital/Hamilton Health Sciences	kodis@hhsc.ca	Acute to Rehab or CCC
Donna Thomson	Directors of CCC	St. Peter's Hospital/Hamilton Health Sciences	thomsondo@hhsc.ca	Acute to Rehab or CCC
Lisa Speck Bouma	eHealth Project Manager	LHIN	speck_l@ghc.on.ca	Acute to Rehab or CCC
Susan Pilatzke	Senior Integration Consultant	LHIN	Susan.Pilatzke@LHINS.ON.CA	Acute to Rehab or CCC
Penny Anguish	Vice President Complex Continuing Care & Physical Rehabilitation	St. Joseph's Care Group	anguishp@tbh.net	Acute to Rehab or CCC
Jane Hodges	Discharge and Transfer Facilitator	St. Joseph's Care Group	hodgesj@tbh.net	Acute to Rehab or CCC
Sabrina Martin	ED/ALC Performance Coordinator	LHIN	Sabrina.martin@LHINS.ON.CA	Acute to Rehab or CCC

Appendix 1: Sub-group Members (3 of 4)

Member	Role/Title	Organization	Email	Pathway Alignment
Paul McAuley	eHealth LHIN Lead & Regional CIO Health Care Network of Southeastern Ontario	LHIN	paul.mcauley@se.ccac-ont.ca	Acute to Rehab or CCC
Nancy Boaro	Advanced Practice Leader, Neuro Program	Toronto Rehabilitation Institute	boaro.nancy@torontorehab.on.ca	Acute to Rehab or CCC
Nathan Frias	Reporting Lead	SIMS	Nathan.frias@uhn.on.ca	Acute to Rehab or CCC
Karen McClure	LHIN Coordinator	LHIN	karen.mcclure@lhins.on.ca	All
Dionne Williams	Director, Transitional Care and Utilization	Bridge Point Health	DWilliams@bridgepointhealth.ca	All
Nancy Hoy	Discharge Planner	Penetanguishene Hospital - Huron District Hospital	hoyn@nsha.on.ca	All
Janet Routliffe	OHISC, Lead eHealth Standards	Health System Information Management & Investment Ministry of Health and Long-Term Care	Janet.Routliffe@ontario.ca	All
Brenda Toonders	Business Lead, IR & ER/ALC, OACCAC Business Solutions and IM	OACCAC	brenda.toonders@ccac-ont.ca	All
Ivana Marzura	Subject Matter Specialist	eHealth Ontario	ivana.marzura@ehealthontario.on.ca	All
Igor Sirkovich	HL7 Methodology Specialist, Information Architect	eHealth Ontario	Igor.Sirkovich@ehealthontario.on.ca	All
Rimmy Kaur	e-Referral Project Lead /Senior Program Manager	CCO	rimmy.kaur@cancercare.on.ca	All

Appendix 1: Sub-group Members (4 of 4)

Member	Role/Title	Organization	Email	Pathway Alignment
Byron Ball	TBC	LHIN	Byron.Ball@LHINS.ON.CA	All
Elaine Gibson	Vice President Complex, Specialty Aging & Rehabilitation Care	Parkwood Hospital, St. Joseph's Health Care London	Elaine.Gibson@sjhc.london.on.ca	All
Dragana Lojpur	Data Standards	Canada Health Infoway	Dlojpur@infoway-inforoute.ca	All
Michael Van Campen	Senior Standards Analyst	eHealth Ontario	michael.vancampen@gpinformatics.com	All

Appendix 2: Care Management Model – Key Functions

Function	Definition	Purpose	Result
Initial Review	<ul style="list-style-type: none"> Initial assessment of patient usually within the first 24 hours of admission using clinical review criteria 	<ul style="list-style-type: none"> Ensure appropriateness of admission and LOC Early identification of potential discharge needs 	<ul style="list-style-type: none"> More efficient utilization of medical resources and beds Proactive continuum of care management planning
Concurrent Review	<ul style="list-style-type: none"> Ongoing assessment of patient using the clinical review criteria 	<ul style="list-style-type: none"> Identify progress, plateau or achievement of goals 	<ul style="list-style-type: none"> Ensures the patient is at the appropriate LOC required by the clinical condition
Discharge Planning	<ul style="list-style-type: none"> Structured and collaborative process for coordination of planning for the discharge or transfer needs of the patient 	<ul style="list-style-type: none"> Early identification of potential discharge needs and planning to ensure all post-acute needs of the patient are addressed prior to the discharge date 	<ul style="list-style-type: none"> Timely and safe discharge of the patient to appropriate LOC or to home Ensures continuity of care between the acute setting, home and/or community
Care Facilitation	<ul style="list-style-type: none"> Focused process to assess, plan and coordinate patient care through the stay from admission to discharge 	<ul style="list-style-type: none"> Proactive management to ensure all aspects of the patients care are met safely and within an appropriate time frame 	<ul style="list-style-type: none"> Eliminate unnecessary delays and/or barriers to care
Continuity Management	<ul style="list-style-type: none"> Structured support and linkages between the acute setting, home and community 	<ul style="list-style-type: none"> Proactive follow-up with discharged patients regarding the post-acute plan and options Enhanced communication across the continuum, including community teams 	<ul style="list-style-type: none"> Early identification of discharge issues Eliminate unnecessary readmissions and improve quality Ensures continuity of care between the acute setting, home and/or community

Appendix 3: Supporting Documents

Useful Acronyms

ADT	Admit, Discharge & Transfer	CIAT	Common Intake Assessment Tool	LTC	Long-Term Care
ALC	Alternate Level of Care	EDW	Enterprise Data Warehouse	MOHLTC	Ministry of Health and Long-Term Care
ALOS	Average Length of Stay	ER	Emergency Room	PIA	Privacy Impact Assessments
ATC	Access to Care	HIS	Health Information System	PRM	Provincial Reference Model
BI	Business Intelligence	HSP	Health Service Provider	RAI-HC	Resident Assessment Instrument-Home Care
CAD	Canadian Dollar	ICU	Intensive Care Unit	RM&R	Resource Matching and Referral
CCAC	Community Care Access Centre	KPIs	Key Performance Indicators	TRA	Threat Risk Assessment
CCC	Complex Continuing Care	LHIN	Local Health Integration Network	WTIS	Wait Times Information System
CCO	Cancer Care Ontario	LOC	Level of Care		
CHRIS	Client Health and Registry Information System	LOS	Length of Stay		

Appendix 3: Supporting Documents

- Detailed Business Process Flows and Requirements are available as separate attachments.

Business Process Flows (PDF):

ALC RMR Business Process Flows Approved Dec 2009.pdf

Requirements (PDF):

ALC RMR Glossary, Functional and Non-Functional Requirements Approved Dec 2009.pdf