Project Charter

Project Name: Parkwood Hospital Access and Flow Project
Proposed working title – Patient Access & Flow Improvement Project – Parkwood Hospital

Current Phase: Initiation

Hospital(s): St. Joseph’s – Parkwood Hospital

Executive Sponsor: St. Joseph’s Senior Leadership Team

Project Sponsor: Elaine Gibson, VP/Complex Care, Specialty Aging & Rehabilitative Care

Project Steering Committee: Parkwood Hospital Leadership Council

Project Leader: Steve Elson, Director, Regional Relations & Special Projects

Project Team: See page 18

Prepared by: Steve Elson
Contributors: Elaine Gibson, Dene Elligsen, Janice Cosgrove, Sharon Jankowski, Beth McCarthy, Karen Masters, Lisa Malbrecht, Dr. Jennie Wells, Parkwood Hospital Leadership Council

Date Issued: December 23, 2010
Version: 5.8
Document Review/Revision History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author/Editor</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dec. 20, 2008</td>
<td>Elaine Gibson</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Dene Elligsen</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Nov. 3, 2009</td>
<td>Elaine Gibson</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Oct 14, 2010</td>
<td>Steve Elson</td>
<td>Updating and adding of new content</td>
</tr>
<tr>
<td>5</td>
<td>Nov 29 2010</td>
<td>Steve Elson/Karen Masters</td>
<td>Updating and editing based on interviews with clinical directors, format changes</td>
</tr>
<tr>
<td>5.1</td>
<td>Dec 1, 2010</td>
<td>Steve Elson</td>
<td>Edits based on feedback from Directors</td>
</tr>
<tr>
<td>5.2</td>
<td>Dec 2, 2010</td>
<td>Steve Elson</td>
<td>Edits based on Dec 2nd meeting with Directors and VP</td>
</tr>
<tr>
<td>5.3</td>
<td>Dec 3, 2010</td>
<td>Steve Elson</td>
<td>Edits to scope and rehab current state</td>
</tr>
<tr>
<td>5.4</td>
<td>Dec 4, 2010</td>
<td>Steve Elson</td>
<td>Edits to Future State</td>
</tr>
<tr>
<td>5.5</td>
<td>Dec 8, 2010</td>
<td>Steve Elson</td>
<td>Edits to project purpose</td>
</tr>
<tr>
<td>5.6</td>
<td>Dec 13, 2010</td>
<td>Steve Elson</td>
<td>Edits to reflect input from Dr. Jennie Wells, Medical Director, Geriatric Medicine, and update of project team members</td>
</tr>
<tr>
<td>5.7</td>
<td>Dec 15, 2010</td>
<td>Steve Elson</td>
<td>Edits to reflect input from Leadership Council</td>
</tr>
<tr>
<td>5.8</td>
<td>Dec 23, 2010</td>
<td>Steve Elson</td>
<td>Updates to Project Team members</td>
</tr>
</tbody>
</table>

Table of Contents

Document Review/Revision History........................................................................................................................................2

1.0 Project Charter Purpose..................................................................................................................................................3

2.0 Project Definition .................................................................................................................................................................3

2.1 Corporate Project Purpose .................................................................................................................................................3

2.3 Project Objectives .................................................................................................................................................................3

2.4 Desired Future State ..............................................................................................................................................................3

2.5 Project Description ...............................................................................................................................................................4

2.6 Current and Future state – success indicators ..................................................................................................................9

2.7 Tolerances ..............................................................................................................................................................................10

3.0 Project Parameters ...............................................................................................................................................................10

3.1 Scope ....................................................................................................................................................................................10

4.0 Project Conditions ...............................................................................................................................................................11

4.1 Assumptions ........................................................................................................................................................................11

4.2 Constraints ........................................................................................................................................................................11

4.3 Dependencies ......................................................................................................................................................................11

4.4 Risks ....................................................................................................................................................................................11

5.0 Project Methodology .........................................................................................................................................................11

5.1 Project Process ..................................................................................................................................................................12

5.2 Project Schedule .............................................................................................................................................................13

6.0 Organizational Impact .........................................................................................................................................................14

6.1 Stakeholder Analysis .........................................................................................................................................................14

6.2 Budget ................................................................................................................................................................................15

6.3 Project Structure .............................................................................................................................................................16

6.4 Project Organizational Structure (reporting relationships) .........................................................................................17

7.0 Approvals ...........................................................................................................................................................................17
1.0 Project Charter Purpose

The project charter defines the scope, objectives, and overall approach for the work to be completed. It is a critical element for initiating, planning, executing, controlling, and assessing the project. It should be the single point of reference on the project for project goals and objectives, scope, organization, estimates, work plan, and budget. In addition, it serves as a contract between the Project Team and the Project Sponsors, stating what will be delivered according to the budget, time constraints, risks, resources, and standards agreed upon for the project.

2.0 Project Definition

The Parkwood Access and Flow Project is a project that will be led by Parkwood Hospital and will be undertaken in collaboration with the hospital services throughout Southwestern Ontario (the Erie St. Clair and South West LHIN) that refer patients to Parkwood Hospital programs, especially the London Health Science Centre (LHSC) which is a primary referral source. It will also involve community services such as the South West Community Care Access Centre (CCAC) that refers patients to specific programs and also facilitates discharge once patients have completed their course of treatment at Parkwood Hospital.

2.1 Corporate Project Purpose

The project purpose is to improve the efficiency and effectiveness of the patient intake and flow processes as they apply to the Rehabilitation, Complex Care and Specialized Geriatric Services, particularly from the point of view of the services that refer patients. The project is linked directly to “Using our resources wisely”.

The project to improve access and flow of patients at Parkwood Hospital is one of the strategic projects under Care and Performance for 2010-11. Decreasing variation and optimizing patient flow will create efficiencies across the system and reduce the wait time in days from acute care to Parkwood Hospital.

2.2 Project Goals

- To improve service provider (referral source) satisfaction with the intake process to Parkwood programs
- To improve the efficiency and effectiveness of the intake process from both a program and Parkwood Hospital-wide perspective
- To make the most effective use of staff resources in order to improve the quality of the patient care (including intake and discharge processes and transfer of patients between programs)
- To improve the flow of patients from Parkwood to home or other care settings

2.3 Project Objectives

- To improve the patient and family experience of the intake and flow process - from both the community and acute care
- To reduce the wait time in days from acute care (inpatient and ED) to specialized programs at Parkwood
- To increase the fit between the patients referred to Parkwood and those who are accepted and admitted
- To decrease ALC days in acute care for patients eligible for Parkwood programs
- To decrease wait time for discharge at Parkwood Hospital
- To identify strategies to address ALC patients in rehabilitation and specialized geriatrics
- To identify opportunities to provide programs that will respond to patient needs and move patients along the continuum of care

2.4 Desired Future State

- All referral sources will have a shared and accurate understanding of the process to be used to refer a patient to Parkwood Hospital.
- The referral and intake process will be transparent, clearly understood and easy to follow.
- Referral sources will not need to pre-define the best fit between the needs of their patient and the specific Parkwood program that best suits their needs. This will be determined by Parkwood staff and physicians in collaboration with the patient, their family, the referral source staff and program experts.
- Intake and admission decision making criteria will be evidence-based and reflect best practices
• Patients in acute care and the community who need the services offered by Parkwood will get access to these services in a timely manner that supports care being provided by the most appropriate provider and program in the most appropriate setting.

• Parkwood will maximize the use of all the human and other resources available in all of its programs to meet the needs of patients in order to serve them in the most effective, efficient and appropriate way throughout the course of their treatment and through the intake and referral process in particular.

• Discharge criteria from Parkwood programs will be clearly understood by everyone. Discharge decision making criteria will be evidence-based and reflect best practices.

• The transfer of information to support decision-making and the provision of patient care will maximize the use of electronic information and tools and will minimize the use of paper.

• Parkwood will continually monitor demands and impact on programs to ensure that the organization continues to provide the most appropriate type and size of programs to meet the changing needs of its patients.

2.5 Project Description

Current State

Preamble: The reason for including a detailed current state as it applies to the focus of this project is to set the stage for beginning to identify the key issues and concerns that will form the focus of the project. The rationale for moving away from the current state needs to be firmly grounded in the current experiences of Parkwood staff and physicians, referral sources and patients. The opportunity to change exists largely if there is the information, experience, perception, belief and motivation to see the current state as not being satisfactory and that change can be made for the better. All of this information has not yet been gathered but it will need to be. As a starting point, a series of interviews with the Directors of the three program areas that are the subject this project: rehabilitation services, complex care and specialized geriatric services were undertaken and most of the material that follows comes from these interviews. The information that follows is both descriptive and evaluative in nature.

Introduction

There is no doubt that the quality of programs offered by Parkwood Hospital is very high. The skills and expertise of the clinical staff and physicians in being able to address the special and complex needs of their patients is not in question. In fact Parkwood is a preferred facility for many health care organizations whose patients need specialized rehabilitation, complex care or geriatric services. There are programs and services offered by Parkwood Hospital that are not available anywhere else in the region. In one case (patients on mechanical ventilators) Parkwood is a provincial resource. In many cases there is more demand for services, especially inpatient services, than Parkwood is able to accommodate.

Rehabilitation

The rehabilitation program at Parkwood Hospital has a number of specialized inpatient and outpatient programs that fall under the umbrella of this program. The inpatient programs include the stroke program, spinal cord injury program, acquired brain injury (ABI) program, amputee program, Neurobehavioural unit (ABI plus severe behaviour problems). The distribution of inpatient beds is as follows: stroke (30), spinal cord (15), ABI (10), amputee (8) and neurobehavioural unit (5). The Most Responsible Physician (MRP) for all of these patients, except the amputee program is a single physician, Dr. John Clement, a family physician. It is Dr. Clement who accepts the patients into care from the referring physicians. In terms of the intake decision, all of the groundwork leading up to the decision to accept a patient is undertaken by Nurse Clinicians and the medical review and approval is undertaken by a physiatrist in collaboration with the Nurse Clinician.

While most referrals to the Rehabilitation Program come from LHSC, other community hospitals refer patients either because they do not have a rehabilitation program or if they do they may lack the critical mass of patients with a particular service need to provide the quality of program they need. For example patients with high level spinal cord injuries will come to Parkwood from Windsor for their inpatient stay and then transfer to outpatient rehabilitation services in Windsor for follow-up rehabilitation. All rehabilitation programs at Parkwood, with the exception of Stroke have a catchment area that includes people who live within the Erie St. Clair and South West LHINs. Stroke catchment is Oxford, Elgin and London/Middlesex. Although each of the rehabilitation programs is specialized, two are qualitatively different: the amputee program and the
neurobehavioural unit. Most patients admitted to the amputee program are admitted from home, not from hospital because their amputation is expected to be fully healed before they come to the program. When they are admitted they are ready to be assessed and fitted for a prosthesis. The other program, the neurobehavioural unit, is one of four in Ontario and they have five beds. Rarely would a patient be admitted from acute care. Most are post rehabilitation patients. They serve a limited and very special needs population, people who have an acquired brain injury that has resulted in moderate to severe behaviour problems. They require very intensive therapy as well as continuous monitoring and support.

In terms of the intake process itself, there are situations when it is predetermined that the patient in an acute care setting will be a suitable candidate for admission to rehabilitation but they are not yet medically stable enough to be admitted to Parkwood. A stroke patient in the Clinical Neurosciences (CNS) unit at LHSC is a good example. A patient recovering from a trauma who has a spinal cord injury is another example of a candidate who may be monitored while they are in acute care, knowing that they will need an inpatient bed at Parkwood in the near future. The decision as to whether a patient is a suitable candidate for a specific rehabilitation program is influenced by a number of factors, their medical stability is important as is their ability to actively participate in reaching their defined rehabilitation goals. If a patient has unstable blood pressure of unknown etiology, for example, it would be highly likely that Parkwood would be sending such a patient back to acute care. Having the physical stamina to actively participate is also important to their success in being able to benefit from the program and then leave. In a program like the brain injury program the needs of the patients can be very intensive, especially in the early stages and so admission decisions will take into account the ‘mix’ of patients already on the floor. In this particular case, admission of trauma patients always are given priority because it is recognized that trauma beds are a scarce resource and being able to make a bed available to serve another trauma patient is important to the intake and flow process within the acute care system. The working relationships that have developed between certain programs at LHSC, e.g., Trauma and Parkwood, between the stoke program’s Nurse Clinician and CNS for example, is such that referrals can be expedited and occur the same day if the patient is rehab ready and a bed is available.

The Nurse Clinicians who work on intake for the rehabilitation program not only collect and review intake information with administrative support, but they also visit the patient at the acute care setting, especially when it comes to LHSC. They visit other nearby hospitals as well but patients are referred from further away patients are processed through a paper process as well as phone calls and Videoconferencing. There are five Nurse Clinicians who manage the rehabilitation intake process. One works in the ABI program, one in the spinal cord program, two in the stoke program and one in Amputee Rehabilitation. The Nurse Clinicians have other responsibilities as well.

In terms of program options there are outpatient and inpatient rehabilitation programs available and people can either be admitted directly to an outpatient program or progress from being an inpatient to being an outpatient. For some follow-up life at home, a group home or in another facility like Long Term Care is an option; for others this is more difficult due to their special needs and the lack of supportive housing in the community or facilities that can meet their particular needs. This creates problems for Parkwood because then they cannot discharge the patient to another living or care setting to enable someone else to come in. More recently community stoke teams have been established in the region and this provides a community rehabilitation option that was not available before. Outpatient services are more cost effective but unfortunately there have been significant reductions throughout the region as a result of budget cuts. Many providers in the community charge fees that can only be covered by third party insurance if patients have limited financial means. This lack of publically funded outpatient services can result in increased lengths of stay on the inpatient rehabilitation program. Budget cuts in other facilities also mean that transferring patients to other facilities to repatriate is delayed. The rehabilitation outreach team provides support and education to service providers and families in the ten county region. They find and work with local services to address the patient’s needs. For stroke patients there is a community stroke team that provides rehabilitation services in people’s homes and community.

**Complex Care**

Complex Care has three different program areas under its mandate: a 20 bed Transitional Care Unit; 20 palliative care beds; and 62 complex continuing care beds. The TCU is a post-acute convalescence unit where it is expected people will stay for a relatively short time and then go home (admissions and discharges from this unit are managed by the CCAC). Palliative care services are provided on two units: (20 beds in total - 14 beds are located on the Palliative Care unit of which 10 are short stay and four are long stay. In addition to this unit, six long-term palliative care beds are located on 3AEast. Finally, the 62 complex care beds provide care to patients with chronic medically complex conditions who require active management within a hospital.
setting. Five of the complex care beds are dedicated to mechanically ventilated patients and are considered to be a provincial resource; two are respite care beds for people with complex needs who are living in the community, leaving 55 general population complex care beds. It should be noted that of these 55, 10 are occupied by long stay residential patients leaving a balance of 45. The complex continuing care beds are provided on two units, 3BWest and 3AEast.

**Transitional Care Unit or TCU (20 beds)** have admission criteria that are specifically intended to facilitate the flow of patients through the unit and then back home or to a LTC facility. Most return home. The average length of stay on this unit is 35-40 days. LHSC is the primary referral source and the catchment area is London-Middlesex. The CCAC Case Manager consults with the nurse practitioner and the family physician who works with the unit to decide on the appropriateness of the admission. The family physician is in charge of the unit although the nurse practitioner can issue orders and works hand in hand with the physician. There are occasionally internal referrals from another program at Parkwood. Most of these patients require restorative care and there is about a 50/50 split between medicine and surgical patients. They are mostly frail elderly persons as the average age is 80. Some are medically frail and many have multiple chronic diseases. Some patients on this unit move on to another program at Parkwood, active rehabilitation for example. The unit has a small therapy team and the focus is restorative care, not rehabilitation.

**Palliative Care** – (20 beds) patients come to this unit from either LHSC or the community via the CCAC. The catchment area is London-Middlesex. There is usually an even balance but recently there have been more patients from LHSC. Patients referred from LHSC are usually referred by the palliative care physicians at LHSC. There are six family doctors who are on call and admit patients to this unit. The admissions process for short stay patients is very streamlined for transfers from another hospital; there is no lengthy form, usually all it needs is a phone call and there is no paper work to delay the intake process. The nurse clinician on palliative care completes an admission form for the unit to identify care and equipment needs prior to transfer. For community referrals, a two page referral form is completed and faxed into the unit. One complication that does arise is contacting the physician on call if they are in their office as their approval is needed before a patient can be admitted. Admissions to this unit occur 24/7. The admissions for the long stay palliative patients are processed by the palliative care nurse clinician and these referrals use the four page admission form required for complex continuing care patients. In addition to the 20 palliative care beds at Parkwood there are also palliative care beds at LHSC. There is a vision to consolidate these beds and this is under discussion.

**Ventilator dependent patients** – (5 beds) as noted above within Complex Care there are sub-populations of patients. One of these is ventilator dependent patients and they can be admitted from anywhere in Ontario. There is a distinct and separate admissions process for these patients. If the patient is not coming from LHSC but from outside of London, the staff at Parkwood works with LHSC (their critical care staff have significant clinical and medical expertise in working with these patients) and the patient will spend 24-48 hours at LHSC before coming to Parkwood. If the patient needs acute care intervention, it is the team at LHSC who will intervene. By using this process, the acute care staff gets to meet and become familiar with the needs of the patient in advance. There is a clinical nurse specialist who manages this intake process.

**Complex Care** – (55 beds) Forms are completed by the referring hospital as part of the admissions process to these beds. In this program there are no staff who go to LHSC or anywhere else to see prospective patients; the completed referral form is faxed over and reviewed. In addition to the information on the referral form, the clinical nurse specialist has access to Cerner and reviews the relevant patient information on the EPR system. Follow-up calls will be made if information is missing. Following this an admissions team meets (once a week) and at that time the application is presented to the team. The team includes a physician as well as nursing, management and therapists. These are people with complex care needs and there needs to be as complete an understanding of their care and equipment needs as possible before admitting them to the unit. For example, one admissions consideration is whether the patient will require a bariatric bed. There are a limited number and if one is not available, the admission may be delayed. A key question is whether the staffing resources are present to address the patient’s needs. The staffing levels can only accommodate a defined number of very high needs patients at any one time. Most admissions come from LHSC but some come from the London Hospitals Alliance or from home. The catchment area for these beds is people who live in London-Middlesex. A concern with the current admission process is that patients are being referred who are found out to not be appropriate and yet it takes staff and physician time and resources to review and process the application. At the same time, there are circumstances under which this program is getting few applications and applications about patients who would be appropriate are not being received. It is reported that the burden of completing the forms is an issue for LHSC staff.
The profile of the patients served by Complex Care indicates that some patients are long stay patients (some of the palliative care patients and those who are living on mechanical ventilators); others may be in this unit because they are medically complex patients whose needs either cannot be safely managed in LTC or they benefit from a slower rehab process with the goal of improving their quality of life. Some patients do go home or to LTC from this program. Most patients come from medical units and have co-morbid conditions; their health is compromised and will continue to be so for some time. Medically complex patients will likely stay due to the lack of a viable alternative. In spite of the fact that these patients may be eligible for LTC home admission, the reality is that they can wait for admission to a LT facility because of their care needs.

LTC has limited capacity to manage tracheotomies, bariatric patients, patient with feeding tubes, or those with significant wounds. The right of LTC facilities to refuse admissions due to the level of care they need in practical terms excludes these patients. The reality is that LTC facilities do not have enough RNs on staff to serve these patients.

In terms of the admissions process to this program there is interest in making the process more coherent and transparent to everyone, including referral sources. This is currently not the case. There is also an interest in speeding up the process so admissions can take place as people are discharged and keep occupancy at an appropriate level. The complex care occupancy rates for 2010/11 were 92.5%.

**Specialized Geriatric Services (or SGS)**

In SGS, a centralized intake process is in place for all geriatric services, including the Regional Geriatric Program (which covers LHINs 1 & 2) and geriatric clinics. Referral forms are completed and then faxed to SGS and two secretaries receive, review and process the applications. Patients are placed in one of two queues, one for inpatients and one for outpatients. Inpatient referrals are entered into Cerner. Like the Rehabilitation program, SGS has nurse clinicians who travel to acute care hospitals (primarily LHSC) to meet the patient and their substitute decision-maker, review the chart and meet with the staff. Using this approach it is possible to collect a lot of valuable information “up front” and also deliver the message that admission to Parkwood does not mean that they can stay indefinitely. The patient needs to be medically stable, have a rehabilitation goal, a discharge goal, and special needs that can be met by the program. If return home is not an option then LTC or transfer to another hospital might be options. If dialysis patients are admitted, the program needs to work around this in terms of scheduling and also the knowledge that when they come back from their dialysis session they will be tired. In terms of physician involvement with the admissions process, the nurse clinician presents the case to the physician and he/she says yes or no. If the physician says yes the program secretary or resource nurse is called and then it’s figured out if a bed is available and if so what kind and when. The wait time for an eligible patient is generally only 1-3 days.

**Musculoskeletal (MSK) patients** - If a musculoskeletal (MSK) patient is involved they will be admitted right away as that is critical to their recovery (fractured hip for example) but if the patient can’t be admitted right away and time lapses, their status and situation will be reviewed again and if they are no longer medically stable then admission would not occur. The nurse clinician will go back to the hospital the day before admission to confirm the status of the patient before they move. All MSK patients, once determined to be a candidate for admission to MSK are reviewed with the MSK physician (there is a roster of physicians who do this) over the phone for a yes/no (90% of the time it is a yes but occasionally the physician will want more information or believe that the patient is a better fit elsewhere i.e. not a good fit for MSK). MSK patients tend to be younger than others (typically 70-75 years of age) and tend not to have complex co-morbidities; they also have a relatively short length of stay. They use rehabilitation services and then are discharged. There are 20 beds for these patients and their rehabilitation is directed by psychiatrists. Most of these patients come from the orthopedic floor at LHSC. Most transition to the Day Hospital at discharge.

**Geriatric Rehabilitation Unit (GRU)** - patients are admitted using essentially the same process as described above (SGS paragraph one) in that the patients are seen, put on a queue and monitored to assess their readiness to be admitted. It should be noted that all patients admitted to the GRU receive a comprehensive geriatric assessment which involves concomitant medical evaluation and treatment during the rehabilitation process. Some patients are taken off the list due to changes in their condition and some decline the offer to come. This process involves review by geriatricians or by the GRU Nurse Practitioner. The review process is different depending on the preferences of the geriatrician who assesses the patient. If patients are in the Acute Care of the Elderly (ACE) program at University Hospital the case will be reviewed with the nurse practitioner in the unit to assess suitability.
In addition to admissions from acute care units, some patients are admitted from the community, including LTC facilities as a short stay - the focus of attention for these patients would typically involve quality of life issues such as learning to transfer to a wheelchair - it's a focused intervention. There is a community nurse clinician who deals specifically with community referrals, of which there are many. The patient in the community is registered in Cerner and if it is determined that the case is not urgent for inpatient admission, the person is put in a queue and a clinical review follows. If the patient is a suitable candidate for the Day Hospital then their application is sent there the same day. Secretaries are an important part of the process. They ensure referral information is complete and follow up when it is not. Many applications are put on hold and processing and decision-making is delayed until all the necessary information is assembled. In addition, referrals come from within - from Parkwood geriatricians who see patients in community settings as well as other staff, OTs and PTs - they will flag people they see in the community at their clinics as candidates for the GRU.

The GRU was established in 1975 when the Parkwood Hospital programs were operated on Grand Avenue. At that time there were 40 beds. The GRU moved to the current Parkwood location on Commissioner's Road when the hospital opened in 1985. At that time, there were 12 Veteran assessment beds and 28 community rehab beds. With declining numbers of Veterans, by 1990 the number of Veteran Assessment beds dropped to four and the number of community rehab beds was 36. In 1997, the physical unit was reconfigured to allow physiotherapy and OT treatment to occur on the unit, reducing the GRU bed numbers to 30 with no veteran assessment beds.

The GAU (Geriatric Assessment unit) with 14 beds - located at the Grosvenor site - was the place where acutely and chronically ill with health concerns were sent for assessment to avoid decline at home and reduction in emergency room visits. This unit opened in 1993 and closed in 2004 with the opening of the ACE. Informally, because of the closure of the GAU, bed inaccessibility in the acute care in the recent climate, as well as enhancement of lab and radiographic capability at Parkwood, geriatricians have opted to use some of the beds for dual assessment, medical treatment/assessment and rehabilitation.

This assessment role also provides a viable and more appropriate alternative to taking these same patients to an emergency department. While the use of beds for this purpose still occurs, the designation no longer formally exists. Some patients who are living in the community may also be brought in as a respite service due to caregiver stress, fatigue or burnout. There are a variety of processes by which patients gain admission to the GRU and this is problematic when decisions need to be made about the relatively priority for admitting patients. It also makes is difficult for referral sources to understand some of the nuances associated with how or why different patient groups are admitted. The patients usually have co-morbid conditions and are very elderly. In terms of discharge, the CCAC is on the floor each day helping with discharge planning for these patients. The average length of stay (year to date) on the GRU is a little over a month at 34.7 days, whereas the average length of stay in the musculoskeletal unit is two weeks shorter at 20.3 (year to date) leading to an average LOS of 27.4 days.

Geriatric Rehabilitation Day Hospital – while there are many outpatient programs and clinics operating throughout Parkwood (and in the community as well) this is the only day hospital program. A new model of service has recently been developed and steps are currently being taken to inform referral sources about the change. A current concern is that this program is suitable for patients who are not being referred. This program offers an alternative to admission through emergency departments for some patients and can also contribute to a shorter length of stay in acute care. Referral sources include acute inpatient units and well as the inpatient SGS unit at Parkwood. The CCAC when they see a client experiencing a functional decline at home refer patients; Geriatricians and family physicians, and emergency department GEM (Geriatric Emergency Management) nurses when they see a gradual functional decline will also refer patients to this program.

In terms of the referral/intake process, the standard SGS intake/referral form is competed and faxed in. The form must have a nurse practitioner or physician's signature. Within 1-2 days the form will be processed and the patient will be contacted by the Day Hospital and offered their first appointment within three days. The first appointment is with nursing and other services get involved depending on the goals that are established. The target population is persons who are frail, elderly (older than 70), with recent functional decline with increased use of emergency department and community health support within the last three months. They must be experiencing declining functional mobility and be able to identify rehab goals. They will have a sub-optimal health status with two or more medical issues that would benefit from two or more therapeutic services such as nursing, OT, PT, SW, RD, SLP. They also need to be able to participate safely.
For the SGS program there is interest in seeing a common, cross program intake process put in place; “one stop shopping” for people looking to refer and admit patients to Parkwood, rather than have referral sources having to know the criteria for each program in order to make an appropriate referral. The intake process needs to be more transparent and less confusing from the point of view of the people who refer to Parkwood. The current processes are costly and time consuming. A standardized approach is needed. There is also an opportunity look at electronic referrals – this is done with hip fractures and it could be expanded to other programs. This is an important consideration from a customer service perspective and as an organization significant clinical resources are being used to manage and coordinate the intake into different programs.

Current State – Summary (draft)
There are many unique aspects to the programs offered by Parkwood, a uniqueness that gives it a special niche in the continuum of care within Southwestern Ontario.

Across the three major program areas and within these areas as well there are relatively independent intake and referral processes. Some are very efficient while others are not. Different staffing models are in place with some programs going to the referral source to gather information and meet with prospective patients; others do not have the resources to adopt this model. There is centralization and standardization within some program areas, but not others. As noted at the outset, there is no question about the quality of the programs once patients get to Parkwood but getting there, especially from an outsider’s perspective, is sometimes not at all clear or well understood - leading to ineligible applications being made and applications being made to the wrong program.

Current state – Conclusion (draft)
From a process improvement perspective, there are likely many opportunities to take unproductive or non-value added time and steps out of the work that is currently being done; time and effort that could be redeployed to do more ‘value added’ work from the perspective of patients, referral sources, physicians and the organization as a whole.

Before finalizing opportunities for change it is important to understand the nature of the issues that exist from different perspectives. Some of this has already been touched on but more needs to be done to fully appreciate the nature and scope of the issues and where change would make a difference.

2.6 Current and Future state – success indicators
These are draft only – they are included to indicate the interest in establishing performance indicators and benchmarks

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Complex Care and Palliative care</th>
<th>SGS MSK</th>
<th>Geriatric Rehab</th>
<th>Stroke</th>
<th>ABI</th>
<th>Spinal Cord</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wait time from acceptance to transfer (appropriate vs ready)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of patients admitted with fit to admission criteria (should be all patients – better to include # patients deemed not a fit for criteria (may not be program specific)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wait time for discharge (days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># leaves (days) of absence within LOS due to return to acute care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># days patient received only 1 rehab service – rehab only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># times benchmarked day of discharge achieved –</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>rehab only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of patients enrolled in outpatient care at discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of hours of therapy per day (?) may be too labour intensive to collect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2.7 Tolerances

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Priority</th>
<th>Describe Tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Time</td>
<td>X</td>
<td>Target is to implement the project on April 1, 2011</td>
</tr>
<tr>
<td>Cost</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Scope</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

### 3.0 Project Parameters

#### 3.1 Scope

**In scope**

- Patients referred from acute inpatient services and the community to:
  - inpatient rehabilitation, specialized geriatrics and complex continuing care programs, excluding the neurobehavioural rehabilitation unit and amputee program
  - Geriatric Rehabilitation Day Hospital
  - Outpatient programs
- Admissions criteria and processes from the point of patient identification to admission
- Discharge criteria processes and barriers to discharge or transfer
- Transfer of patients between inpatient programs at Parkwood (including Veterans and other programs that may be out of scope)

Detailed areas to be considered are: program admission criteria, an analysis of inpatient versus outpatient rehabilitative services, an analysis of weekend passes, an analysis of source of admissions, an analysis of systems to identify patients for complex, specialty aging and rehabilitative inpatient services, readiness for transfer, discharge criteria, discharge process with decreased variation, education requirements.

The project will include developing and implementing a new intake and patient assessment model for Parkwood programs that fall within the scope of this project.

- There is a need to clarify admission and discharge patient criteria to decrease duplication between programs, eliminate multiple assessments for different Parkwood programs and decrease variability in processes for Parkwood programs
- There is a need to create clarity of patient admission criteria for acute care partners

**Out of scope**

- Veterans’ care
- Amputee program
- Transitional Care Unit program
- Neurobehavioural rehabilitation program
- Components of the operations of Parkwood Hospital outside of those defined as being in scope
- Implementing a new discharge planning and patient transfer process for the Parkwood programs will not fall within the scope of this project. The focus will be on the intake and referral process.
- Outpatient and day hospital admissions processes that do not originate in an inpatient acute care setting
4.0 Project Conditions

4.1 Assumptions

- Project includes Complex, Specialty Aging and Rehabilitation programs
- There is a gap in ambulatory care for neurology (stroke) patients in the region
- Veteran excluded due to involvement of VAC in admissions and no need for discharge planning
- There will be ongoing pressure on acute beds requiring more access to Parkwood services
- CCAC may be responsible for admissions to complex care and rehabilitation in the future

4.2 Constraints

The challenge will be gaining agreement for change in the current culture. Time of clinicians and physicians to become engaged is a second constraint.

4.3 Dependencies

- This project is a small part of a LHIN wide Access Project. It will be important to avoid overlap or duplication with the larger LHIN project.
- Parkwood is part of a complex web of interdependent services that provide healthcare throughout Southwestern Ontario and therefore any significant changes in services offerings, admission or discharge policies by others may impact Parkwood programs’ ability to both discharge patients and provide continuity of care through other programs, services and organizations.
- The planned opening of 22 inpatient rehabilitation beds as well as day programs and outpatient services at Woodstock General Hospital in November 2011 will likely have an impact on Parkwood’s rehabilitation program but the nature and size of that impact is not known at this time.

4.4 Risks

<table>
<thead>
<tr>
<th>#</th>
<th>Risk</th>
<th>Probability (High/Med/Low)</th>
<th>Impact (High/Med/Low)</th>
<th>Action to Prevent/Manage Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Resistance to change processes</td>
<td>High</td>
<td>Medium</td>
<td>Engage in process</td>
</tr>
<tr>
<td>2</td>
<td>Lack of objective data</td>
<td>Medium</td>
<td>Medium</td>
<td>Identify current state data early</td>
</tr>
<tr>
<td>3</td>
<td>Financial implications to hospital and LHIN if there is a shift to increase Ambulatory services</td>
<td>High</td>
<td>High</td>
<td>Develop a business plan to shift resources and create win-win</td>
</tr>
<tr>
<td>4</td>
<td>Unable to deliver within predefined timeframe</td>
<td>Low</td>
<td>Low</td>
<td>Extension of project timeframe</td>
</tr>
<tr>
<td>5</td>
<td>Concern from staff re loss of job</td>
<td>High</td>
<td>Medium</td>
<td>Articulate at beginning purpose of project</td>
</tr>
<tr>
<td>6</td>
<td>Enabling legislation to change role of CCAC in admission process</td>
<td>High</td>
<td>High</td>
<td>Include CCAC in change process</td>
</tr>
</tbody>
</table>

5.0 Project Methodology

Overview

- Using LEAN principles, the focus of attention will be on improving the intake and flow process in terms finding ways to improve safety, effectiveness, patient centredness, timeliness, efficiency and equity. By clarifying admission criteria it is expected the referral process will be easier and less time consuming for referral sources and more satisfactory for patients and their families.

- Utilization of rehabilitation, complex care and specialized geriatrics services need to be maximized. By improving intake processes and decreasing variable access to inpatient beds, day hospital and outpatient programs are expected to improve.
Areas to be addressed are admission criteria, discharge criteria, processes for admission, discharge and process of care delivery. Documentation and information collection and dissemination and how it impacts flow will be included.

Alternative intake, assessment and discharge processes will be explored and will be evaluated and assessed against the LEAN principles outlined above.

A preferred process or model that serves the best interests of Parkwood Hospital as a whole will be identified, selected, planned for, implemented, monitored and improved.

5.1 Project Process

Phase One – why change?
The initial focus of attention will be to clearly define the current state and build a case for change. The case for change needs to satisfy the interests and needs of referral hospitals and internal stakeholders - physicians, clinical leaders and front line staff. Part of this will be a matter of communications; for others it will require more active engagement and dialogue. Why change will require different reasons from different groups. Everyone has to be clear on why this project is being undertaken. Why change? Why now?

This is key to being able to move forward with the project.

Phase Two A – Current State
A current state analysis will need to be undertaken for several reasons:
To be able to identify before and after scenarios
To be able to flag before and after system performance measures
To be able to identify key characteristics of the change model that will be selected

Phase Two B – Future State
A future state analysis will need to be undertaken for several reasons:
To be able to identify before and after scenarios
To be able to flag before and after system performance measures
To be able to identify key characteristics of the change model that will be selected
To be able to reflect back to stakeholders the key characteristics of the new model and assess their support

Everyone has to be clear on what the change will look like, how it will be different and the benefits of the proposed change

Phase Three – modelling
Moving from the current to the future state – What should the new model look like? Factors to consider include:
Organizational structure – reporting and accountability
Workflow – improved referral and discharge process
Staffing – composition, role definitions etc, scope of work
Work will include model selection and testing.

The focus of this project will be on the intake process through which patients are identified, referred, assessed and admitted to Parkwood’s programs. It will not focus on the discharge processes although the link between access and discharge will be made.

Phase Four – implementation planning
Once the change model has been selected and approved, the next step will involve developing an implementation plan to move the model from concept to operational reality. This part of the planning process, to be successful, needs to actively involve the leaders who will be taking responsibility for the on-going operation of the new model.

Phase Five – pre-implementation training and communications
This project phase will involve staff training and orientation to their new roles and to the new model. It will also include a significant amount of time in communicating the pending change to both internal and external stakeholders. This work will be built around the agreed upon “GO LIVE” date for the new model.
**Phase Six** – implementation and rapid cycle changes
This project phase will involve the actual implementation of the model and rapid cycle changes – as required – around the new process, expecting that not everything will have been anticipated and that quick changes will need to be made, especially in the early days.

**Phase Seven** – 30 day post implementation – operational assessment of the initial impact and responses

**Phase Eight** – Three month review of the impact and responses to the changes – including both quantitative and qualitative data collection, analysis and reporting

**Phase Nine** – Formal closeout of the project – may include a six or nine month post implementation evaluation

### 5.2 Project Schedule

<table>
<thead>
<tr>
<th>#</th>
<th>Project Milestone</th>
<th>Date Estimate (YYYY/MM)</th>
<th>Deliverable(s) Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Project team members recruited and meet for the first time</td>
<td>December 2010</td>
<td>Project team members confirmed.</td>
</tr>
<tr>
<td>3</td>
<td>Project Steering Committee recruited and meets for the first time</td>
<td>December 2010</td>
<td>Steering Committee members confirmed – including Chair</td>
</tr>
<tr>
<td>4</td>
<td>Phase 1 – Why Change?</td>
<td>January 2011</td>
<td>Rationale for the proposed change clearly stated, agreed to and communicated</td>
</tr>
<tr>
<td>5</td>
<td>Phase 2 – Current and Future state documented</td>
<td>March 2011</td>
<td>Documentation of current and desired future state re: intended operational outcomes</td>
</tr>
<tr>
<td>6</td>
<td>Phase 3 - Intake and flow model approved. Intake model to be implemented approved</td>
<td>April 2011</td>
<td>Intake and flow model</td>
</tr>
<tr>
<td>7</td>
<td>Phase 4 – Intake Model implementation planning complete</td>
<td>May 2011</td>
<td>Implementation plan</td>
</tr>
<tr>
<td>8</td>
<td>Phase 5 - Pre-implementation training and communications complete</td>
<td>June 2011</td>
<td>Completed pre-implementation training and communications</td>
</tr>
<tr>
<td>9</td>
<td>Phase 6 - Model Implemented</td>
<td>July 2011</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Phase 7 - Post-implementation assessment undertaken</td>
<td>September 2011</td>
<td>Post implementation assessment report</td>
</tr>
<tr>
<td>11</td>
<td>Phase 8 - Three month post-implementation evaluation completed</td>
<td>November 2011</td>
<td>Evaluation report</td>
</tr>
<tr>
<td>12</td>
<td>Phase 9 - Project formally closed – closeout report written and accepted by the project Steering Committee</td>
<td>December 2011</td>
<td>Close-out report</td>
</tr>
</tbody>
</table>
# Organizational Impact

## Stakeholder Analysis

<table>
<thead>
<tr>
<th>Stakeholder (name and title)</th>
<th>Interest/Stake</th>
<th>Project Role/Involvement</th>
<th>Communications</th>
<th>Relationship Manager (Point Person)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERNAL STAKEHOLDERS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Leadership Team</td>
<td>Organizational interests improved access and flow, achieved benchmarks improved patient care with clear plans and accountability improved performance</td>
<td>Approve project moving ahead Approve implementation</td>
<td>• Regular updates from Project sponsor through SLT meetings • Circulation of project bulletins</td>
<td>Elaine Gibson</td>
</tr>
<tr>
<td>Physician Leaders from each program (Rehab, SGS, Complex Care)</td>
<td>• Improved access and flow, increased patients served • Achieved benchmarks • More efficient use of resources</td>
<td>Steering Committee Member Member of the Physician Leaders Group Member of the Parkwood Hospital Leadership Council</td>
<td>• Participation in Physician Leaders Group • Participation in Steering Committee meetings • Circulation of project bulletins</td>
<td>Physician Lead</td>
</tr>
<tr>
<td>Administrative Leaders from each program (Rehab, SGS, Complex Care)</td>
<td>• Improved access and flow, increased patients served • Achieved benchmarks • More efficient use of resources</td>
<td>Steering Committee Member Member of the Parkwood Hospital Leadership Council</td>
<td>• Participation in Steering Committee meetings • Circulation of project bulletin</td>
<td></td>
</tr>
<tr>
<td>Clinical leaders (Rehab, SGS, Complex Care) including PPLs and staff</td>
<td>Improved access and flow, increased patients served</td>
<td>Identification of current issues, concerns</td>
<td>• Circulation of project bulletins</td>
<td></td>
</tr>
<tr>
<td>Staff responsible for both intake and discharge process</td>
<td>• Change in role and responsibilities • Training and orientation to new role</td>
<td>Identification of current issues, concerns Participation with project team in developing model and scope of new work</td>
<td>• Active engagement • Face-to-face meetings, conversations • Circulation of project bulletins</td>
<td></td>
</tr>
<tr>
<td>Front line staff</td>
<td></td>
<td></td>
<td></td>
<td>• Circulation of project bulletins</td>
</tr>
</tbody>
</table>
### Stakeholder (name and title) | Interest/Stake | Project Role/Involvement | Communications | Relationship Manager (Point Person)
--- | --- | --- | --- | ---
**EXTERNAL STAKEHOLDERS**

**Referring hospitals (intake)**  
LHSC, MHA  
All LHIN 1 & 2 hospitals  
Improved access  
More effective use of time, simpler, clearer process  
Less work  
Identification of current issues, concerns  
Feedback on preferred intake model  
- Circulation of project bulletins  
- Opinion and experience survey

**Referring Physicians (intake)**  
LHSC, MHA  
All LHIN 1 & 2 referring physicians  
Improved access  
More effective use of time, simpler, clearer process  
Less work  
Identification of current issues, concerns  
Feedback on preferred intake model  
- Circulation of project bulletins

**SW CCAC**  
Improved coordination – intake and discharge processes  
Identification of current issues, concerns  
Feedback on preferred intake model  
- Circulation of project bulletins

**SW LHIN**  
System integration  
Improved effectiveness  
Improved patient access  
Reduced wait times  
- Circulation of project bulletins

**Specific units in hospitals – that are primary referral sources**  
Improved access  
More effective use of time, simpler, clearer process  
Less work  
Identification of current issues, concerns  
Feedback on preferred intake model  
- Circulation of project bulletins

---

**6.2 Budget**

Replacement of clinical team  
$30,000

<table>
<thead>
<tr>
<th>ONE TIME COSTS:</th>
<th>Dollars (x1000)</th>
<th>Comment</th>
<th>Class of Estimate (A/B/C/D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff (contract or backfill)</td>
<td>30K</td>
<td>8 sessions of 4 hours x15 staff@$60.00</td>
<td>C</td>
</tr>
<tr>
<td>Training</td>
<td></td>
<td>Lean Six Sigma Training</td>
<td></td>
</tr>
<tr>
<td>TOTAL ONE TIME COSTS:</td>
<td>$30K</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| ONGOING COSTS: | | | |
|---|---|---|
| Staff (contract or backfill) | | |
| Leases | | |
| Licenses | | |
| Other | | |
| TOTAL ONGOING COSTS: | | |
6.3 Project Structure

- It is proposed that the project be structured as follows:

Role of the St. Joseph’s SLT
- To approve the project and ensure its strategic alignment with organizational priorities, and strategic plan
- To address any issues brought to its attention by the Project Steering Committee

Role of the Project Steering Committee
- To approve the Project Charter
- To receive status reports provided by the project team
- To approve the new intake & discharge model
- To approve the implementation plan
- To approve the pre-implementation training and communications plan
- To approve the go-live date
- To address any operational or strategic issues brought to its attention by the project team

Role of the Physician Leaders Group
- To provide physician input into the project
- To provide project team members with advice and direction regarding physician specific issues needs and concerns
- To provide input to the Project Steering Committee
- To review and provide feedback on draft materials

Role of the Project Team
- To provide staff leadership and direction to implementing the project charter
- To report on an on-going basis to the Steering Committee
- To anticipate and address project management issues on an on-going basis and to escalate issues outside the scope of responsibility or authority of the team to the Steering Committee
6.4 Project Organizational Structure (reporting relationships)

**Executive Project Sponsor**
St. Joseph’s Senior Leadership Team

**Project Sponsor**
Elaine Gibson, VP/Complex, Specialty Aging & Rehabilitative Care

**Project Steering Committee Members (proposed)**
Parkwood Hospital Leadership Council

**Core Project Team**
Regional Relations & Special Projects – Director, Steve Elson (Project Lead)
Organizational Development & Learning Services - Corporate Facilitator, Dene Elligsen
Communication and Public Affairs - Consultant, Anne Kay
Quality Measurement and Clinical Decision Support – Consultant, Heather McHale
Strategy & Project Leadership - Process Improvement Consultant, Maurice Williams
Rehabilitation services – Spinal Cord Injury program – Nurse Clinician, MaryAnn Regan
Rehabilitation services – Stoke – Coordinator, Eileen Britt, and Nurse Clinician, Kim Hay
Complex Care – Clinical Nurse Specialist, Janet Hunt and Nurse Clinician for Palliative Care Janette Burton
Specialized Geriatric Services – Nurse Clinician, Lise Goettl

**Physician Leaders Group**
Physician leaders who will act as consultants and advisors to the project team

---

7.0 Approvals

<table>
<thead>
<tr>
<th>Name, Project Role</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkwood Hospital Leadership Council</td>
<td></td>
<td>December 15, 2010</td>
</tr>
<tr>
<td>St. Joseph’s Senior Leadership Team</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>