UHN

Toronto General
Toronto Western
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Toronto Rehab

UHN-Toronto Rehab

Demonstrating Value and Enhancing Quality Outcomes

Report to the Toronto Central LHIN | July 31, 2012

Contents

Introduction	*3*
Highlights	*4*
Breathing Easy: how a new respiratory therapy role in complex continuing care is making a difference	*5*
Corporate Services Integration	*6*
Reinvesting in rehabilitation and complex continuing care	*7*
It's Hip to be Prepared: responding to the increasing complexity of an aging population	*9*
Demonstrating value with health system partners	*10*
Establishing integration measures related to enhancing quality care and patient outcomes	*11*
Dealing with Stroke Head On: creating a seamless and more efficient stroke care continuum	*13*
The next six months	*14*
Summary	*14*

Introduction

It was just over a year ago that Toronto Rehab and University Health Network (UHN) formally came together as a single organization. It's remarkable how much we've accomplished in such a short time, which is why I am excited to share with you our second integration progress report.

Our integration was built around a commitment to enhance patient experiences and improve access to quality care. The decision to bring the two organizations together was also about maximizing our resources to provide greater value for our patients and the health system.

In our first report published in January 2012, we showcased our nine corporate services integration priorities aimed at creating a single organizational culture and support infrastructure. This work is nearly complete, with some final IT-related activities forming the last phase toward achieving our goal.

"As patient needs become even more complex within an aging population, the reinvestments in rehabilitation and complex continuing care are set to support the entire health system, from acute care to home." – Dr. Bob Bell

In our second report – *"Demonstrating value and enhancing quality outcomes"* – we focus on clinical performance and the myriad ways our integration is benefiting our patients and partners. We've begun to establish and track quality indicators related to clinical outcomes and the satisfaction of our patients' experiences and journeys. And we have stayed true to our commitment to maintain access to inpatient rehabilitation and complex continuing care for our referring hospital partners.

We're also pleased to share with you some of the exciting activities underway to reinvest integration-related savings into the rehabilitation and complex continuing care services within Toronto Rehab – an important integration commitment.

Approximately $2.5 million – savings directly realized through the integration and consolidation of many corporate and support services functions and systems – have been invested thus far on initiatives aimed at enhancing quality patient care, ensuring timelier access to inpatient and outpatient rehabilitation and improving patient flow from acute care to post-acute care. As patient needs become even more complex within an aging population, the reinvestments in rehabilitation and complex continuing care are set to support the entire health system, from acute care to home.

Our experience this past year has also informed how we talk about ourselves as an academic health sciences network. We have begun to embrace what it means to be not an *integrated* organization, but simply what it means ***to be*** UHN. With Toronto Rehab as a vital part of who we are, we're now focused on what our future looks like as a new organization, one well positioned for success in an evolving health system and austere fiscal reality.

In recognition of our new organizational identity, on June 20, 2012 we unveiled – at our first annual general meeting since the integration was formally approved – a refreshed brand that we believe sets us apart from other hospitals and reinforces just how meaningful each of our clinical programs are in defining who and what UHN is, and our collective value to our patients and partners.

Most importantly, it reconfirms our promise as well as our belief that ***courage lives here***, and that our people – from patients, staff and volunteers, to physicians, students and scientists – are at the centre of each of our accomplishments and innovations. This includes a successful integration between two leading Ontario health-care organizations that we hope will serve as a model to others.

Sincerely,

Dr. Robert Bell, MD, CM, MSc, FRCSC, FACS
President and CEO
University Health Network

Highlights

Since our last report, we have continued to achieve a number of goals and reach key milestones in our integration, aligned with our strategic domains below.

In our Caring domain, we have:

- ✓ Reinvested approximately $2.5 million in savings following the integration into inpatient and outpatient rehabilitation and complex continuing care services.
- ✓ Maintained patient satisfaction in rehabilitation and complex continuing care.
- ✓ Introduced a new respiratory therapist role at the E.W. Bickle Centre, utilizing expertise from Toronto Western and Toronto General for this complex continuing care patient population.
- ✓ Maintained Toronto Central LHIN referring hospital access to inpatient rehabilitation and complex continuing care programs.
- ✓ Hosted family and resident council meetings at the E.W. Bickle Centre for Complex Continuing Care and Lakeside Long-Term Care Centre to hear feedback related to their experiences post integration.
- ✓ Expanded the existing relationship between Toronto Rehab and Toronto Western toward strengthening the *Neuro Collaborative*, an initiative designed to improve timely access to rehabilitation for people living with a stroke or brain injury.
- ✓ Completed a LEAN-based collaborative exercise with Toronto Western, Toronto Rehab, Sunnybrook, St. Michael's Hospital, Canadian Paraplegic Association (CPA) Ontario and the Toronto CCAC to improve experiences of people with spinal cord injuries across the continuum.
- ✓ Created a single Brain and Spinal Cord Rehabilitation Program to take advantage of the clinical expertise and research discoveries in a single neurosciences rehabilitation program.
- ✓ Achieved a national distinction, for the second time, as a stroke rehabilitation leader following a successful review of the Toronto Rehab Stroke Service by Accreditation Canada.
- ✓ Launched a new brand for the organization which now formally acknowledges Toronto Rehab as a distinct clinical program within UHN.
- ✓ Completed a planning exercise for Toronto Rehab involving clinical and corporate teams from other areas of UHN to inform the evolution of the program.
- ✓ Reinvigorated the annual staff flu vaccination competition, resulting in Toronto Rehab Lyndhurst Centre having the most improved vaccination rates for a rehab centre and both Princess Margaret and Toronto Western having the best overall vaccination rates among all hospitals in the GTA last year.

In our Academic domain, we have:

- ✓ Continued to expand e-learning and virtual library options to Toronto Rehab program staff.
- ✓ Received a prestigious academic award from the University of Toronto recognizing the quality educational experiences awarded to Occupational Therapy students at Toronto Rehab.

In our We domain, we have:

- ✓ Completed corporate services integration activities, including intranet content migration, payroll systems, email integration, financial systems integration and human resources policy harmonization, among others.
- ✓ Celebrated the commitment to staff wellness as the 2012 Inter-Hospital Wellness Challenge champions.
- ✓ Continued to expand leadership and ongoing organizational development and training activities to Toronto Rehab program staff.

In our Creative domain, we have:

- ✓ Published a digital report called "A World Inside" featuring rehab research activities from the past year including research involving scientists from Toronto Rehab, Toronto General and Toronto Western.

In our Accountable domain, we have:

- ✓ Advanced the preliminary planning work for the capital renovation of the E.W. Bickle Centre for Complex Continuing Care.
- ✓ Prepared for the final phase of the University Centre redevelopment which will result in the inpatient MSK rehabilitation program at Hillcrest Centre moving to University Centre in January 2013.

Breathing Easy: *how a new respiratory therapy role in complex continuing care is making a difference*

Opal Roper is a long-time complex continuing care resident who has had problems with her lungs for as long as she can remember. Since coming to Toronto Rehab's E.W. Bickle Centre for Complex Continuing Care from St. Joseph's Health Centre eight years ago, Opal's pre-existing condition has resulted in recurrent lung infections, breathing difficulties and a previous traecheostomy which have resulted in frequent transfers to acute care for emergency respiratory intervention.

In April 2012, Opal developed a sudden severe problem with her breathing and was showing signs of a chest infection, both of which needed immediate attention. Normally, Opal would have been transferred to acute care for necessary medical intervention. Instead, thanks to the arrival of a new registered respiratory therapist (RRT) on a rotation from Toronto Western Hospital, Opal received the intervention she needed – in this case deep lung suctioning to remove a potentially serious mucous plug – at Bickle Centre.

"Typically, when a patient develops difficulty breathing and shows signs of a lung infection, we transfer the patient to acute care to receive the respiratory intervention they need before returning," says Greta Mighty, program services manager at the Bickle Centre. "Now we are more able to manage these types of situations right here, which is much better for the patient and more cost effective for the health-care system."

Roughly one in five residents at the Bickle Centre is living with a traecheostomy, which is initiated in acute care when a patient needs long-term ventilation or frequent lung suctioning. Knowing how common traecheostomies are likely to become as our population ages and as more people are diagnosed with chronic disease, respiratory specialists from Toronto Western and Toronto General have introduced their expertise to Bickle Centre to become part of the care team. They provide onsite care and support for patients, help prevent common problems with traecheostomies, avoid costly transfers to acute care and help provide education and training to an already skilled interprofessional team.

"Our goal is to have fewer acute care transfers, enhance patient care and educate the interprofessional team so that we can, together, achieve those goals," says Angela McGauley, an RRT at Toronto Western for 20 years who helped Opal on her very first day in her new role at the Bickle Centre.

Complex continuing care resident Opal Roper feels in great hands with the care team at the Bickle Centre, which has recently been enhanced with the addition of registered respiratory therapists from Toronto Western and Toronto General such as Angela McGauley (background).

"The respiratory team is trained to deal with situations that require a rapid response," adds Angela, who helped the team avoid a transfer of another patient for similar complications within a week of helping Opal. "That's why we're excited to work with the care team at Bickle Centre – to look at ways we can apply those practices and experiences to the program and to learn from each other in the process."

The use of RRTs was made possible through the integration as it allowed for greater opportunities to develop stronger collaborative ties across acute care and post-acute care boundaries. Greta feels that the role is an important part of an interprofessional team whose expertise is collectively being enhanced to care for more complex patients.

"Toronto Rehab already had great ties with other UHN clinical programs; the integration simply reinforced those relationships," she says.

To Opal, the benefit of having the new RRT role is much simpler: "I didn't like having to go back and forth between hospitals; I much prefer staying here at Bickle Centre where I'm comfortable."

Progress update: creating a single organizational culture and support infrastructure

In our first integration report, we profiled the work of our Corporate Services Integration Committee and their mission to help create a single culture and corporate services infrastructure for the new organization. Since then, this work has continued with many of the priorities now accomplished.

Corporate Services Integration Committee from L-R, bottom row: Michael McGuire, David Uzan, Frank Tourneur, Boguslawa Trojan, and Emma Pavlov; top row: Mathew Kennedy, Adele Wentzel, Catherine Clarke and Todd Leach. Not pictured: Susan Grove, Kim Bellissimo, Darlene Dasent, Katherine Henning, Michael Sheeres, Mandy Lowe, Michael Caesar, Michelle Gariepy, Chris Pickard and Velta Vikmanis.

Creating a single staff intranet: Status: Complete ✔
One of our priorities as a new organization was the operation of a single corporate intranet. Last fall, we initiated an intranet integration project aimed at migrating priority Toronto Rehab intranet content to the existing UHN corporate intranet site. On April 11, 2012, this work was completed, officially marking the operation of a single intranet for all of UHN.

Integration of payroll systems Status: Complete ✔
This initiative was the first major information system integration project for the SIMS team. It involved retiring the existing Toronto Rehab Empath payroll system and migrating staff information to the UHN VIP payroll system. The data transfer and system integration were completed on January 5, 2012.

Integration of financial systems Status: Complete ✔
The extension of SAP, a financial management system used at UHN, to Toronto Rehab was formally complete on April 1, 2012, ensuring the use of a single financial management and accounting system for the entire organization.

Domain and email integration Status: On Track ✔
The integration of email addresses is a major initiative to help remove communication barriers and strengthen the feeling that we are part of a single organization. On April 1, 2012, the email systems were fully integrated, ensuring that the newest members of UHN were assigned an @uhn.ca email address. The larger information network domain initiative involves formally bringing two different data networks together and streamlining the network sign-in process for all staff. The analysis is well underway and a detailed integration plan is in development, with a target for completion of fall 2012.

Integration of compensation and benefits Status: Complete ✔
UHN benefit options were rolled out to Toronto Rehab employees in April 2012, providing further opportunities to streamline and create consistency in the management of benefits for employees organization-wide. In addition, following a series of town hall meetings held at Toronto Rehab sites in the fall of 2011, compensation and benefit policies, along with other HR policies, have been harmonized to ensure equity in the application of human resources practices.

Single EPR Status: On Track ✔
We have initiated an EPR (electronic patient record) enhancement project to implement changes to the current UHN/Toronto Rehab EPR desktops and securities. This will allow for seamless sharing of clinical information with all UHN sites. The plan is to start implementing the enhancements in four phases, concluding in February 2013.

Creating a shared sense of community and culture Status: Complete ✔
On February 1, 2012, all Toronto Rehab staff gained access to the UHN eLearning Centre, designed to provide staff with access to educational opportunities 24 hours a day, seven days a week, from any computer with internet access. Toronto Rehab program employees now have access to more than 200 eLearning modules as well a wide variety of professional development classroom sessions. As well, recent manager retreats focused on building leadership resiliency that brought all leaders from across UHN together for learning and community building.

Organizational development and education program offerings continue to be made available at Toronto Rehab locations, providing Toronto Rehab staff with extended opportunities for professional development. Over the last year, a total of 18 Toronto Rehab specific education courses have been attended by nearly 260 staff. In total, 86 courses have been held for about 1,100 staff throughout all UHN sites including those at Toronto Rehab.

All UHN staff at Toronto General, Toronto Western, Princess Margaret and Toronto Rehab how have access to a consolidated Virtual Library, with more than 5,000 electronic journal titles, 2,800 eBooks, numerous biomedical databases and point-of-care tools.

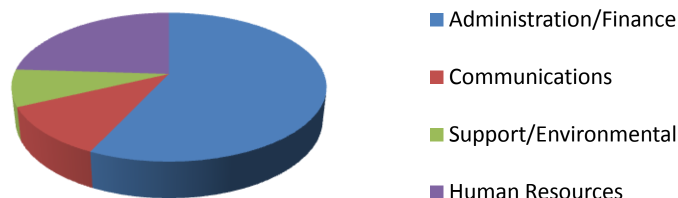
Reinvesting in rehabilitation and complex continuing care

We made a commitment to the Toronto Central LHIN and to our health system partners that savings from the integration would be reinvested into direct patient care activities within the rehabilitation and complex continuing care programs.

The integration provided several opportunities to realize savings through a number of ways. Some of these savings were immediate while others are, and will continue to be, ongoing. A majority of those savings have been earned through streamlined leadership positions, material savings associated with consolidated departmental/ program budgets, among other efficiencies within corporate services (See Fig. A).

Additional integration-related savings will continue to be identified and reinvested into rehabilitation and complex continuing care over time.

Fig. A - Savings sources $2.5 million



Approximately $2.5 million has been committed for reinvestment towards clinical activities that are aligned with these integration objectives:

- Meets integration commitments
- Is in the spirit of Toronto Rehab's program vision – revolutionizing rehabilitation and maximizing life
- Supports UHN and system priorities related to quality, access and flow
- Effective and efficient use of available resources
- Evidence-based best practices

A total of five projects focusing on building capacity and access, intensification and quality (see Fig. B) were initiated, as follows:

Building system capacity and access

High-tolerance stroke care

The Stroke Service at University Centre will, along with intensification of rehabilitation aimed at reducing a patient's overall length of stay in hospital, open three inpatient beds in fall 2012, resulting in an additional 16 inpatients being admitted to the program each year. With this investment, the Stroke Service will also introduce a Stroke Fast Track Outpatient Service to ensure quicker access to outpatient services as patients are discharged from either acute care or rehabilitation hospitals.

Maintaining low tolerance, long duration for a vulnerable population

The investment in the Stroke Service means that resources are now available to maintain five Low-Tolerance Long-Duration beds at the Bickle Centre. The Low-Tolerance Long-Duration Rehabilitation Service helps meet the unique needs of this complex continuing care patient population who are normally not candidates for typical intensive inpatient rehabilitation.

Intensification of rehabilitation and patient flow

Neuro rehabilitation

The stroke and brain injury services will introduce seven-day-a-week inpatient rehabilitation, commencing fall of 2012. Intensifying rehabilitation services is expected to reduce the overall length of stay for admitted patients by concentrating rehabilitation care over a shorter period of time. We anticipate this project will allow us to admit up to 60 more inpatients annually and reduce length of stay for neuro rehab by seven days, which will benefit access and flow for patients admitted to the program from all hospitals within the Toronto Central LHIN.

MSK rehabilitation

The MSK (musculoskeletal) Rehabilitation Program, currently located at Hillcrest Centre but soon moving to our University Centre in January 2013, also will be introducing seven-day-a-week rehabilitation and will enhance outpatient service capacity with a focus on providing more outpatient services for less complex cases. This intensification within the inpatient program will allow it to admit more complex patients quicker, something critically important as more people have complex orthopaedic surgeries. This initiative also supports the Toronto Central LHIN's mandate to ensure simple hip and knee replacement patient cases are discharged to the community rather than to an inpatient rehabilitation program, which evidence has shown results in positive outcomes for patients.

Enhancing quality

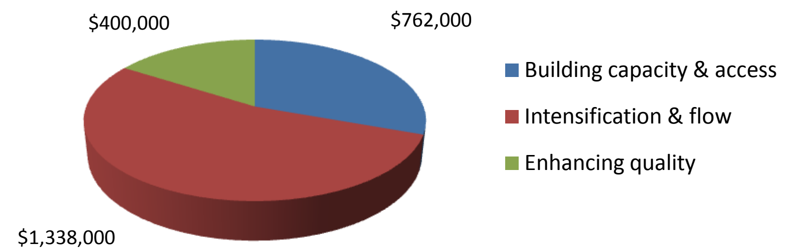
Advanced practice nursing resources for Geriatric Rehabilitation

As our population ages, we're finding that the needs of patients admitted to our Geriatric Rehabilitation program are becoming more complex. To help address this, we are investing in the recruitment of two specialized advanced practice nurses into the program. The additional resources will help reduce the number of urgent transfers to acute care where nursing expertise can be applied to intervening before a medical issue escalates. We expect to have these new roles in place by fall 2012.

Enhancement of Pharmacy Services

As the number of patients and complexity of the cases we see increase, we recognize that we need to enhance the capacity of our Pharmacy services to match those needs. Investments are being made to provide additional staff and other resources to the Pharmacy team to allow us to meet those needs and to help accommodate the shift to seven-day-a-week rehabilitation in selected programs.

Fig. B - Reinvestment commitments $2.5 million



The next steps for reinvesting in rehabilitation and post-acute care

As we move forward with our first round of reinvestments, we will continue to look for additional savings from our integration and direct those savings as appropriate to the Toronto Rehab program in support of patient care.

It’s Hip to be Prepared: *responding to the increasing patient complexity linked to an aging population*

Complex hip and knee injuries and diseases can stop people in their tracks. It can also stop the health system from working efficiently without the right models of care in place to help people return home faster after hip and knee replacement surgery. That’s the premise behind the recent integration-related investments in musculoskeletal (MSK) rehabilitation at Toronto Rehab.

“It’s about system transformation and about building capacity to meet growing demand,” says Dr. John Flannery, medical director at Toronto Rehab’s MSK Rehabilitation Program. “Evidence shows us that patients with single knee or hip replacements have equally good outcomes going straight to home from acute care. So the rehab focus needs to be on helping patients with more complex conditions.”

The inpatient MSK Rehabilitation Program, currently located at Hillcrest Centre, will introduce new care models that will see it treat more complex patients, provide seven-day-a-week therapy and treat more patients through its outpatient program. Dr. Nizar Mahomed, chief of orthopaedics at Toronto Western, believes that improving capacity within rehabilitation will allow for greater flow of patients through the system and decrease pressures on acute care by minimizing wait times.

“I expect to see a significant increase in demand in the next decade for hip and knee replacements, which place added pressure on the entire system,” he says. Both Drs. Flannery and Mahomed view the integration as an opportunity to build on a history of collaboration between Toronto Rehab and UHN’s orthopaedic and MSK teams.

“The Total Joint Network and Fractured Hip Rapid Assessment Teams were piloted at Toronto Rehab and Toronto Western and are now standards of practice province- wide,” says Dr. Mahomed. “These projects showed that different parts of the system can come together to solve problems in a very effective way. Creating a more seamless care system for complex hip and knee patients is something we expect to see as an important outcome.”

Laurel Reigo knows all about the experience – and life-changing benefit – of having a hip replacement. The 65-year-old grandmother of a busy toddler and newborn twins was a successful business owner with her husband and lived an independent life until she started experiencing severe and debilitating pain in her hips.

For more than three years she lived with her worsening condition—a combination of arthritis, a malformation of her hip bones and multiple sclerosis.

Dr. John Flannery, medical director of the MSK Rehab Program, believes that investments in the program will help improve capacity for more complex hip and knee replacement cases. Ruth Vallis, (background in white) physiotherapist, works with a hip replacement patient

“I couldn’t do anything. I literally felt like I was done, that it was all over for me,” says Laurel, recounting how she lost her independence and ability to do even the simple things in life. “I couldn’t even take two steps up the stairs without feeling physically beat and in a serious amount of pain. I felt incredibly old.”

Feeling helpless and hopeless, she eventually discovered that she was an excellent candidate for bi-lateral hip replacement surgery. Soon after, doctors at Toronto Western performed the surgery on her right hip and within five days of the surgery she was transferred to Toronto Rehab’s MSK program. There she underwent daily physiotherapy to get her strong and confident enough to go home.

“The pain was gone almost immediately once I had the surgery. But the big challenge was to get me walking again,” says Laurel. After four weeks in rehab, she returned home. “The team at Hillcrest provided such flabbergastingly exceptional care. I almost forgot what it was like to live without any pain. I am very grateful.”

Within just three months of her right hip replacement, she had surgery on her left hip and again was transferred to Hillcrest Centre, where she stayed for just three weeks before going home. Although she still has challenges with her stamina, Laurel is independent and is enjoying a quality of life that she hasn’t experienced in years. She’s also enjoying being physically-able to keep up with her grandchildren.

But most of all, there’s one thing that her experience with UHN has given her, something she has not had in more than three years: ***Optimism.***

Engaging patients and families

During the due diligence phase of our integration in early 2011, we reached out to patients and residents to solicit their feedback about the integration and to both reassure and commit to them that quality patient care is a top priority and will continue to be following the integration. We also committed to staying in touch and providing opportunities to report on our progress and solicit ongoing feedback.

Patients and residents of our complex continuing care and long-term care programs were particularly important stakeholders as their satisfaction and input would serve as a reliable barometer for the impact of the integration on vulnerable patient populations.

When program leadership met with the Bickle Centre patient and resident council on June 14, 2012, members were asked about their experiences since the integration. David Dell, whose son is a long-time resident of the Bickle Centre, is an active member of the council. He and other members maintained their desire to see investments made in the physical facilities at Bickle Centre and were pleased to hear that progress is being made in the planning now underway to renovate the centre and introduce a new dialysis program, made possible through the integration.

More importantly, to David and other members of the council, the integration has been a welcome, and smooth, transition.

"I would say that the whole process has been pretty seamless," says David. "It's great to hear about some of the benefits of the integration. Bickle is a wonderful place, and now there's a sense that things are happening in the background to enhance the capabilities of the program. For us, we just would like to make sure that Bickle has a voice and that investments are made in the centre, which is home to many residents and is a second home to many families."

Program leadership plans to visit the Bickle Centre and Lakeside resident councils every few months to continue monitoring feedback.

Working with our partners towards better experiences for people with spinal cord injuries

Toronto Rehab's Lyndhurst Centre is home to one of Canada's largest inpatient spinal cord rehabilitation programs. In April 2012, spinal cord rehab staff, along with health professionals from Sunnybrook, St. Michael's Hospital, Canadian Paraplegic Association (CPA) Ontario, Toronto Central CCAC and UHN's Toronto Western Hospital initiated a Value Stream Mapping project to look at ways, through the use of LEAN methodology, to improve the care experience for spinal cord injury patients from acute care to home.

This cross-functional team of caregivers and patients were brought together at a retreat at Lyndhurst Centre in late March 2012 to map out the patient experience and highlight opportunities around key goals that improve experience and ultimately outcomes. The results of the value stream mapping have helped inform the development of three clinical streams in the spinal cord rehab program, which is currently in development. Results will also be used to develop ideas for rapid improvement events.

"Because of our close relationships it makes tremendous sense that the key players come together and collaborate on ways to improve the patient experience," says Peter Athanasopoulos with CPA Ontario. "We can't make a meaningful impact without working together. That is what made the retreat so valuable."

CPA Ontario's Peter Athanasopoulos, bottom right, works with other members of the value stream team at Lyndhurst Centre, including staff from Toronto Western.

Enhancing quality patient care and clinical outcomes

The most important objective related to the integration of Toronto Rehab and UHN was that the coming together of the two organizations would enhance the patient care experience and quality of care. A number of quality indicators have been identified for patients who are admitted to rehabilitation and complex continuing care at Toronto Rehab-UHN which includes indicators that will track the quality of care across the entire continuum.

As we shared in our first report, we view our integration as a two-year process as it will take some time for the reinvestments in rehabilitation and other enhancements in patient care to begin to have an impact. Now that we have established baseline quality indicators, we will carefully monitor progress against these baseline figures and will report on clinical indicator performance in our final submission to the Toronto Central LHIN in June 2013.

These indicators, which are accepted industry metrics used to evaluate the quality of rehabilitation and complex continuing care services in the province, are as follows:

- *Episode of Care focuses on length of stay from acute care to rehabilitation, including patients referred from UHN and non-UHN acute care centres.*
- *Transitions to Rehabilitation focuses on the number of readmissions back to acute care from rehabilitation within seven days of original transfer.*
- *Ambulatory Rehabilitation Visits compares against hospital accountabilities and the additional capacity being built within the system to accommodate more patients into rehabilitation services.*
- *FIM (functional improvement measure) change measures the changes of level of independence in performing tasks involved within the FIM instrument.*
- *FIM efficiency measures the FIM changes made by patients in relation to how long they stayed in rehabilitation.*
- *Prevalence of stage two pressure ulcers as a measure of sustained quality nursing care and patient outcomes within a complex continuing care environment.*
- *Patient/Resident/Family Satisfaction measures the quality of a patient's experience in the inpatient rehabilitation program and the perspectives of patients and families in the complex continuing care program and long-term care at Lakeside.*

When we announced the integration we also made a commitment to our referring Toronto Central LHIN hospital partners (Sunnybrook, St. Mikes, St. Joseph's, Toronto East General, Mount Sinai) that we would continue to support system access and flow to inpatient rehabilitation and complex continuing care beds. Baseline figures for admissions from referring partners have now been established based on previous years' patterns.

Inpatient Rehabilitation

Referring Hospital	2011/12	2010/11 Baseline
TEGH	31	25
St. Michael's	120	142
Sunnybrook	210	213
Mount Sinai	134	147
St. Joseph's	337	340

Inpatient Complex Continuing Care

Referring Hospital	2011/12	2010/11 Baseline
TEGH	4	7
St. Michael's	12	23
Sunnybrook	5	5
Mount Sinai	8	7
St. Joseph's	110	106

In June 2012, a full year post-integration, we reached out to our referring partners with a report on these admission volumes and sought their input. Feedback received thus far indicates that we are on the right track. We will continue to work with our partners to develop new models of care that maximize patients' independence so they can return home safely.

Clinical indicator summary and highlights

While we will be including a report on clinical outcomes in our final report to the Toronto Central LHIN, initial observations in selected clinical areas reveal encouraging results following the integration:

- ✓ Overall inpatient rehabilitation patient satisfaction scores have remained stable following the integration.
- ✓ There has been an overall reduction in the number of patients transferred to emergency departments and readmitted within seven days of transfer to inpatient rehabilitation or complex continuing care.
- ✓ The number of stage-2 pressure ulcer cases at the Bickle Centre has decreased by 1.2% compared to last year.

- ✓ The MSK Rehabilitation Program has reduced inpatient admissions for simple hip and knee and non-fracture patients.
- ✓ In the brain injury service, we've reduced average length of stay by 7%, decreased the number of readmissions by 1%, increased the number of admissions by 4%, and improved outpatient visits by 16%.
- ✓ In the spinal cord service, we increased the number of admissions by 6% and reduced length of stay by 2%.

Dealing with Stroke Head On: *creating a seamless, first-class stroke care continuum*

Stroke is expected to remain a leading cause of hospitalization and disability in Canada as our population ages and as more people are living with chronic conditions such as diabetes and cardiovascular disease. Getting patients access to quality rehabilitation quicker from acute care is one of the ways Toronto Rehab-UHN is aiming to address this growing demand head on.

Prior to the integration, Toronto Rehab and UHN's Toronto Western Neurovascular Unit created the *Neuro Collaborative*, an initiative aimed at speeding up transfers to rehabilitation and sharing expertise and information across the continuum to reduce lengths of stay and alternate level of care days among stroke and brain injury populations. It also involved the creation of a unique *flow coordinator*, solely responsible for connecting patients with the right care at the right place at the right time.

This initiative had begun to show positive outcomes prior to the integration. Now, the collaborative has only been strengthened, providing even more opportunities to share resources between acute care and rehabilitation to improve services for patients recovering from stroke and brain injury.

When **Pablo Boada**, 35, had a stroke and was admitted to Toronto Western, he was eager to begin rehabilitation so he could return home to his family. After just nine days in acute care, he was transferred to Toronto Rehab's Stroke Service where he was immediately placed in an intensive therapy regimen aimed at helping him reach his personal health goals.

Seven weeks later, Pablo – who came to Toronto Rehab unable to move his left side and sit up in a chair – left able to walk on his own, looking forward to spending time with his son and returning to the things he enjoyed most in his life prior to his stroke.

"I found the transition overwhelming but my care team made my transition comfortable," says Pablo. "My therapists pushed my limits, which I always encouraged. They knew I wanted to work as hard as I could on my rehab goals."

It is the promise shown by the *Neuro Collaborative* and positive experiences of patients like Pablo that reinforce the value of integration-related investments in stroke care at Toronto Rehab-UHN. Not only will investments open up three new beds in the inpatient Stroke Service, it will enable the stroke and brain injury services to implement seven-day-a-week rehabilitation– an intensification of therapy that has been shown to achieve quality patient outcomes within a shorter timeframe.

Pablo Boada works out with physiotherapist Marika Schwandt at Toronto Rehab's Stroke Service, which will be seeing more patients thanks to enhanced collaboration with Toronto Western and other activities designed to improve access and flow from acute care to rehabilitation.

"This means patients who are admitted can achieve their goals faster through intensified therapy and thus we can rehabilitate even more patients in the stroke program," says Dr. Mark Bayley, medical director for the Brain & Spinal Rehabilitation Program at Toronto Rehab-UHN. "Building this capacity in the program supports a Toronto Central LHIN mandate to improve the flow of stroke patients across the continuum and, quite simply, provide better patient care."

Along with enhanced inpatient capacity, the program believes the changes will allow it to admit up to 60 more stroke patients each year. Integration-related investments will also help expand capacity in outpatient stroke rehabilitation, including the addition of a Fast Track Service aimed at getting people access to outpatient therapy quickly so they don't need to access inpatient rehabilitation.

The Stroke Rehab Service at Toronto Rehab has played a leading role in Canada as demonstrated by receiving for the second time, the Stroke Distinction Award from Accreditation Canada.

The next six months

Over the remaining summer and fall months, teams will put the finishing touches on planning for the implementation of rehabilitation reinvestment projects. We will also be wrapping up the final planning phases of a number of corporate activities such as the domain integration and will have initiated the EPR integration project.

Our third report, in December 2012, will focus on integration achievements in education and research – two of our strategic priorities that help set UHN apart from other institutions. We're looking forward to sharing those stories.

Summary

An integration is not a simple transaction. It requires the contributions of many people from within UHN and outside the organization. It also requires a steadfast commitment to achieving what we set out to achieve in bringing two world-class organizations together: to build a better health system for our patients.

We are well on our way. And we are optimistic that the next year will be just as rewarding and challenging as we ramp up the reinvestment initiatives and continuously find ways to define what it means to be UHN and what it takes to make a patient's care and experience along the health-care continuum the best it can be.