The 'Planning Considerations for Reclassification (PCRC) of Rehab/CCC Beds Initiative was established in January 2014 in response to significant discussion amongst stakeholders on the topic of re-classification of complex continuing care (CCC) to inpatient rehabilitation beds in the context of Health System Funding Reform (HSFR) and the emerging Rehabilitative Care Alliance Definitions Framework. The mandate of the PCRC task and working groups was to identify a standardized approach that both Local Health Integration Networks (LHINs) and Health Service Providers (HSPs) can use when considering the reclassification of CCC to rehabilitation beds. Their work has resulted in the development of a toolkit that outlines considerations and supports the process of completing due diligence once a potential need to re-classify beds is identified. The toolkit also describes a process to be undertaken to prepare the business case for the Reclassification of CCC/Rehab beds – should this be deemed to be appropriate/required. While some components of the toolkit (e.g. the 'HBAM Calculator', sections of the education module) apply only to HBAM-funded hospitals, the toolkit was developed to provide all system planners with insights into potential considerations associated with determining the need for and/or completing the process of reclassifying CCC/Rehab beds as part of a comprehensive rehabilitative care system capacity planning exercise.

The PCRC Task Group has developed the following tools to support LHINs and/or Health Service Providers to complete due diligence when considering the reclassification of CCC/Rehab beds:

1. Process to Assess Need for Re-Classification of CCC/Rehab Beds
2. Education Modules
    A. Financial and Clinical Considerations for Re-classification of Rehab/CCC Beds
    B. Implications of the RCA Definitions Framework & Proposed Directions
3. Stakeholder Risk / Benefit Considerations
4. PCRC Case Studies/Scenarios describing the experiences of organizations that:
    A. are considering re-classification
    B. have completed re-classification
    C. have collected dual coded data[1] (including why it was collected and what story the data told)
5. National Rehab System (NRS) Grouper – 2014-15 Provincial RPG Cost Weights
6. HBAM Calculator
7. Potential System-Level Data Analysis to Support Re-Classification Considerations
8. Re-Classification Evaluation Criteria

Appendix - Guidelines for Hospital Beds Re-Classification, LHIN Liaison Branch, Relations and Coordination Unit, MOHLTC

[1] 'Dual Coded Data' refers to the collection of both NRS and MDS measurement tools for patients who are receiving rehabilitative care in either rehabilitation or complex continuing care beds.

1. Process to Assess Need for Re-Classification of CCC/Rehab Beds

Potential Drivers of Re-Classification

LHIN-Level Rehabilitative Care System Capacity Plan completed every 3-5 years

Policy/System Motivated
New RCA Definitions
Assess and Restore Guideline

Clinically Motivated
Lack of Flow
Achievement of Best Practice

Financially Motivated
Rehabilitative Care Provided to Patients in CCC May Not Be Adequately Funded

Do capacity plan and system drivers suggest the need to explore re-classification of beds? If yes, complete 'Feasibility Analysis' (including # of beds to be re-classified)

Business Case Preparation

Does 'Feasibility Analysis' support need to re-classify beds? If yes, determine process and documentation required by LHIN (i.e. "Guidelines for Hospital Beds Re-Classification") including:

- Proposed bed patient/program configuration – CCC/Rehab bed mix, patient/case mix
- Demonstration of alignment with LHIN and provincial directions/planning
- Description of anticipated financial impact including funding/QBP impact, interim funding solution to mitigate time lag before HSFR calculations reflect reclassification (i.e. how will higher rehab costs be funded in the intervening years?), co-payment/semi-private revenue, hospital margin 3-year proforma, capital costs, staffing/HR impact
- Reporting implications (CIHI)
- Evaluation Outcomes/Metrics
- Where relevant, appropriate community engagement
- Description of anticipated impact on system (flow, ALC etc.)

Business Case Review by LHIN

Business Case Approval, Revised HSAA and HAPS

Monitor/Evaluate

TOOLS

RCA Capacity Planning Framework
RCA Definitions Framework
RCA Evaluation Framework

- Education Modules
  - A. Financial and Clinical Considerations for Re-classification of Rehab/CCC Beds
  - B. Implications of the RCA Definitions Framework & Proposed Directions
- Stakeholder Risk / Benefit Considerations - Patient/Caregiver & HSP Considerations

- PCRC Case Studies/Scenarios
- RPG Cost Weights 2014/15
- HBAM Calculator
- Potential System-Level Data Analysis Requirements to Support Re-Classification

- LHIN Business Case Template
- Guidelines for Hospital Beds Re-Classification, LHIN Liaison Branch, Relations and Coordination Unit, MOHLTC (Appendix A)

- Stakeholder Risk / Benefit Considerations - Patient/Caregiver & LHIN Considerations
- Re-Classification Evaluation Criteria

2. Education Modules

A. Financial and Clinical Considerations for Re-classification of Rehab/CCC Beds

B. Implications of the RCA Definitions Framework and Proposed Directions

3. Stakeholder Risk Benefit Considerations

This tool has been created to support LHINs and Health Service Providers (HSPs) to complete due diligence when considering the re-classification of Complex Continuing Care (CCC) beds to inpatient rehabilitation beds in the context of clinical outcomes, financial and policy implications. It is intended to support consideration of critical questions and issues when considering the need for and implications of re-classifying rehab/CCC beds. Partial or complete enabling/mitigation strategies are offered (where available).

Overarching Questions for Consideration:

- Does re-classification align with the Rehabilitative Care Alliance's Standardized Definitions Framework and the MOHLTC's Assess and Restore Guideline?
- What are the implications of re-classification, based on new standardized definitions, on the rest of the system? For instance, will re-classifying the beds preserve sufficient CCC capacity to serve the needs of the system?
- Is there evidence (research or clinical) that patients who are currently receiving rehabilitative care in CCC beds, will have a shorter LOS (i.e. within the CIHI/NRS ELOS) as a result of receiving higher intensity therapeutic services (i.e. inpatient rehabilitation intensity)?
- Will provider and/or system savings (e.g. reduced LOS, admission avoidance to LTC) be realized such that re-classification is at least cost neutral (in the context of the increased costs to operate a NRS/rehabilitation versus a CCC bed)?
- Are the implications/considerations different for stand-alone facilities versus acute care centres with rehab/CCC beds?
- Are the implications/considerations different for small hospitals?
- What criteria should be used to determine the number of beds that are appropriate for re-classification as well as critical mass for rehabilitative care services?
- What are the implications of re-classification on individual organizational funding under HSFR, as well as on the incremental system dollars required to fund the re-classification?

Section 1 - Risk Benefit Considerations for Patient/Caregiver

CLINICAL ISSUE for PATIENT/CAREGIVER	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
System Responsiveness	• May support the system to be more responsive to patient's fluctuating functional needs i.e. Patients may be more likely to receive services that are required vs services that are available in the bed to which they are assigned. • By placing patients in beds that are associated with increased therapeutic resources, there is a potential for increased responsiveness to patients changing functional tolerance with increased rehabilitation assessment/treatment opportunities. • May provide an opportunity to "right size" bed numbers based on system need/demand • May support system's ability to address the growing need for geriatric rehab (i.e. a growing specialty rehab population) • Larger critical mass of rehabilitative care beds may allow for flexibility and diversity of programming for patients	• Structure funding/service delivery models with the flexibility to provide a range of intensity as per expected population recovery trajectory (MOHLTC/LHIN/HSP)	• Potential risk of reducing intensity of rehabilitation for high intensity rehabilitation populations as fixed resources distributed amongst higher volume of patients • Patients may not be motivated/ functionally able to take advantage of increased therapy • The system may be less able to respond to patients who deteriorate. • Will need to ensure that achievement of goals is reasonable within shorter LOS for the patient population that is being considered for reclassification. • Potential for increased acute ALC as lower functioning patients may have increased difficulty accessing rehabilitative care beds due to concerns related to expected LOS	• Update NRS ELOS system to reflect the complexities of frail elderly persons with multiple interacting comorbidities (MOHLTC) • Fund beds at the necessary level to achieve the BP guidelines in relation to frequency and intensity of therapy services (MOHLTC) • Ensure maintenance of intensity of rehabilitation by using the dollars to convert to fewer beds with the expectation of greater throughput. (LHIN/HSP) • Define (RCA) and implement (LHIN/HSP) practice models consistently across the health care continuum that support standardized models of care delivery within bedded levels of rehabilitative care • Ensure staff work to full scope of practice (rehab assistants may be under-utilized with respect to staffing complement or utilized at a level which does not maximize their scope of practice) (HSP) • Not all sites with designated rehabilitation beds fall under HBAM (e.g. smaller rural sites with limited number of beds)
Patient Transfers	• May minimize patient transfers between programs i.e. currently patients may be transferred from CCC to rehabilitation to attain a higher level of therapeutic intervention once their tolerance increases.	• Ensure that there is a process for patients to be assessed on an ongoing basis for need, capacity, tolerance for therapy and progress towards goals and support care plan adjustments as appropriate regardless of the type of bed that they are in (HSP)	• May make it more difficult to transfer patients who may still be admitted to a CCC bed once reclassification occurs (due to decreased capacity/increased demand for rehabilitation) • The population described as being targeted for re-classification may require more nursing care and may be more fragile in terms of their	• Clear eligibility criteria (RCA) and increased ability to determine need and responsiveness in the system to address those needs and move as necessary

CLINICAL ISSUE for PATIENT/CAREGIVER	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
			propensity to slip back into an acute phase of illness. Process will need to be in place to ensure patents have access to a suitable/higher level of medical care in the event that it is required.	
Best Practice Care	• May support achievement of population-specific best practices as population specific programs that offer a broader intensity of therapeutic services may be developed, along with clinical expertise etc. • May drive standardization and consistency across the continuum amongst hospitals across the LHIN to ensure best practice and high quality rehabilitative care services, improving a patient's experience through their rehabilitative care journey • May support development of clearly defined rehabilitative care goals for specific diagnosis/streams. • Greater efforts working towards early mobilization may contribute to improved outcomes, shorter LOS • There may be greater access to interdisciplinary teams in rehabilitation • Enables fundamental rehabilitation philosophy and environment to maximize patients progress and goal attainment, supporting timely and safe discharge to home	• Working groups to provide provincial rehabilitative care best practice, evidence based guidelines (TBD).	• More rigid LOS (as determined by ELOS/QBP target LOS) may place patients at risk of being transferred home/LTC without meeting all rehabilitative care goals	• Consider organizational return on investment with respect to ensuring best practice models are used with specific rehabilitation populations, as this may support better patient outcomes, shorter lengths of stay, and improved patient quality of life post discharge (HSP) • Develop and endorse rehabilitative care best practice guidelines (TBD) and staffing complement guidelines (RCA) to ensure standardization in the intensity and scope of rehabilitative care services are available
Access	• Increased opportunity for patients who may previously not been accepted to rehabilitation to access resources • Less confusion navigating the system resulting in greater patient/caregiver satisfaction.		• Potential risk of declining admission to complex/higher needs patients (i.e. those historically served in CCC) from inpatient rehabilitation due to concerns about not meeting the NRS ELOS target which may	• Clear eligibility criteria (RCA) • Appropriate funding model – if these patients require therapy at the level of a rehabilitation bed in order to maximize outcomes and reduce long stay

CLINICAL ISSUE for PATIENT/CAREGIVER	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
	• May support access for patients who present initially with low function but who have significant restorative potential[2] and are expected to tolerate intensive rehabilitation. • May increase access as the same patient populations are served with shorter LOS as a result of increased intensity of rehabilitation.		contribute to ALC pressures in acute care.	institutionalization and increased costs in the system, then funding is required to include this type of patient in rehabilitation beds (MOHLTC) • Develop new ELOS targets specific to complex/higher needs patients (MOHLTC)
Patient Safety	• Access to a dedicated interdisciplinary team / increased therapy intensity in rehabilitation may support a more comprehensive assessment and treatment of functional deficits contributing to improved preparedness for transfer home.	• Ensure sufficient staffing levels to assist families with coping, skills acquisition, discharge planning, and home safety (HSP)	• Potential risk of discharging complex/higher needs patients (i.e. those historically served in CCC) too soon in order to meet the ELOS target	• Appropriate goal setting (HSP) • Early, ongoing and enhanced transition planning (HSP) • Standardized discharge criteria (HSP)
Data Collection	• Reporting to NRS as opposed to MDS/CCRS will facilitate improved data quality related to functional outcomes and enable analysis by population/diagnosis	• NRS data collection and reporting system already in place. • Will reduce workload due to challenges with analysis that is required to conduct system analysis amongst two systems that do not align.	• MDS/CCRS supports comprehensive assessment of frail and/or complex adults whereas NRS is more focused on function without considering the other geriatric syndromes that may be contributing to frailty. • MDS/CCRS supports cross continuum care planning so not completing it on frail and/or complex adults may create a gap in the care planning for these patients.	• If a frail/geriatric patient is appropriately placed in an inpatient rehabilitation bed based in their functional need and requires a comprehensive geriatric assessment and/or is anticipated to required CCAC support upon discharge, the RAI MDS could be completed while in inpatient rehabilitation (in addition to NRS FIM) to inform the development of a cross continuum care plan (HSP/CCAC)
Change Management			• Existing patients & families may not be prepared for transition to accelerated discharge planning and focus	• Graduated approach to transition (HSP)

[2]Restorative Potential means that there is reason to believe (based on clinical assessment and expertise and evidence in the literature where available) that the patient's/client's condition is likely to undergo functional improvement and benefit from rehabilitative care. The degree of restorative potential and benefit from the rehabilitative care should take into consideration the patient's/client's:

- Premorbid level of functioning
- Medical diagnosis/prognosis and co-morbidities (i.e., is there a maximum level of functioning that can be expected owing to the medical diagnosis /prognosis?)
- Ability to participate in and benefit from rehabilitative care within the context of the patient's/client's specific functional goals and direction of care needs.

Note: Determination of whether a patient/client has restorative potential includes consideration of all three of the above factors. Cognitive impairment, depression, delirium or discharge destination should not be used in isolation to influence a determination of restorative potential.

Section 2 - Risk Benefit Considerations for Health Service Providers (HSP)

CLINICAL ISSUE for HSP	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
Best Practice Care	• May support the development of critical mass. • May support the development of clinical focus/expertise with respect to the types of services offered to maximize clinical outcomes.	• Clear rehabilitative care best practice guidelines with defined outcome expectations (TBD). • Education for staff and communication to entire team (HSP) • Physician engagement (HSP) • Order sets (HSP)		
Access	• May support improved clarity for referrers	• Rigorous screening of referrals to ensure appropriateness of patients (HSP)	• The more complex patients may have a longer LOS leading to interruptions in patient flow and reduced availability of beds for more appropriate patients who may be waiting from acute care. • May increase ALC issues for acute care as more complex patients might not be accepted to rehabilitation. • Patients with higher FIM scores may have reduced access to rehabilitation in order to provide opportunities for patients with lower FIM scores (i.e. the re-classified population)	
Incentives	• May support achievement of QBP/best practice targets (e.g. stroke inpatient rehabilitation)		• Sustainability is a risk if funding continues to decline at the current rate for hospital based programming	
Change Management			• Training may be required to up-train staff re: required data reporting/ clinical outcomes • Resources may be required to support adoption/ change management • Physician Engagement – need to ensure right patient admitted to right bed	• Build a communication plan that address information needs at all stakeholder levels (TBD)
Operating Costs	• Increased opportunity for group treatment to maximize efficiency.	• Full HBAM funding (MOH) • Additional one time funding options for	• Additional resources may be required to fund the increased resources/therapeutic	• Resource allocation for additional services (MOH/LHIN)

CLINICAL ISSUE for HSP	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
	• With increased volumes, able to more effectively utilize support personnel and group interventions. • Allows for maximizing utilization of human resources and expertise as well as supplies and equipment costs • If HBAM funding allocation is applied, those with higher rehabilitation services and more complex medical needs SHOULD have a higher CMI and therefore benefit with additional funding for services required allowing for these professional services to be budgeted • HSP's may achieve return on investment due to shortened LOS and achievement of best practice targets through allocating increased resources to support intensified rehabilitation	program set-ups and reallocation, education (MOH/LHIN) • Create programs with sufficient critical mass to optimize the use of support personnel and group interventions that meet best practice (LHIN/HSPs)	intensity to the re-classified population e.g. PT/OT Speech Therapy professional, OTA/PTA services, ?nursing, ?pharmacy • Potential increase in equipment needs for exercise, space issues, wheelchairs etc. • May increase demands for discharge planning in rehabilitation beds for more complex patients • Need to consider the impact on remaining CCC patients/rest of system if move HR and/or physical rehabilitative care resources along with re-classified beds. • If slow stream rehab beds are re-classified (and these patients are no longer served within CCC) the CMI in CCC will drop. Need to look at CCC beds that are not moving and consider the CMI within those remaining beds.	• Appropriate funding i.e. not just moving current CCC/SSR resources but reviewing funding based on rehabilitation patient in a rehabilitation bed
System Responsiveness	• Increased ability to provide assessment and treatment based on patient functional changes and with improved multidisciplinary focus of all team members		• May reduce flexibility in bed utilization particularly in small hospitals where bed numbers are small • If patients are discharged earlier, need to consider the capacity of community services to support patients. • Need to develop mitigation strategy to respond in the event that slower stream complex patients who do not meet ELOS	• Ensure programs with sufficient capacity distributed within a geography vs within each facility (LHIN)
Human Resource Implications	• With increased critical mass may be able to set staffing ratios that optimize the use of support personnel		• Need to ensure staff possess the appropriate skills and scope to effectively treat new population • Union issues may need to be addressed if staff are assigned to a different unit • Potential severance costs	

CLINICAL ISSUE for HSP	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
			• May require one-time training regarding rehabilitative care philosophy • Small sites may not have access to physiatry • May be capital equipment needs	
Financial	• Individual organizations might be able to increase revenue once beds are designated in a standardized way, if they can mobilize resources to maximize gains which align with system goals (improved flow, shortened wait times, reduced ALC, maximized clinical outcomes in the shortest LOS possible). These funds could potentially be re-allocated to increase capacity in outpatient services • Potential to support improved physician model/coverage (i.e. Physicians can bill daily in NRS/rehabilitation beds, once to twice per week in CCC) • Under HSFR, organizations that deliver intensive therapeutic resources in CCC, as may be required by patient functional tolerance to improve patient outcomes and reduce LOS, may lose funding under the HBAM performance component of HSFR (by looking inefficient).		• HBAM projects future service levels (i.e. weighted cases and potentially weighted days in the future) which may not reflect actual future weighted volumes • Need to anticipate impact of potential changes in patient revenues on hospital margins e.g. consider impact on the revenue from patient co-payments • Need to consider the impact of reclassification on HBAM service variances. Reclassification to rehab could reduce service variances and negatively impact overall variances and hence affect overall HBAM funding. Lag may have negative impact in year beds are moved from CCC to rehab (i.e. in rehab, actual will be greater than expected (negative variance)). • Anticipated impact of HSFR is evolving and is largely based on a prior year's performance, hence a time lag before HSFR recognizes reclassification. • The source of the incremental system dollars required to fund the increased therapy resources within re-classified beds to rehab will need to be identified • Under HSFR, the re-classification of beds from CCC to rehab could leave organizations with a two year funding gap (unless there is mitigation). The source of funds to support operation (i.e. increased rehabilitation	• Mechanisms under HSFR to accommodate system changes will need to be developed so that HSFR does not become a deterrent to making patient-centered changes within CCC and Rehab that may support improved patient outcomes and shorter lengths of stay (MOHLTC) • Clarify the role of the MOHLTC in addressing any potential funding impact to avoid a large disruptive change (MOHLTC) • Re-classification may not be one to one i.e may need to operate fewer rehabilitation beds with additional funds allocated towards operations (i.e. increased therapy) (LHIN/HSP) • Develop new RPG for slower stream rehab patients (MOHLTC) • Revise ELOS for current RPGs to better reflect /fund slower stream patients in rehabilitation (MOHLTC) • Develop trim point in rehabilitation beds for ELOS outliers (MOHLTC)

CLINICAL ISSUE for HSP	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
			intensity) within re-classified beds will need to be identified (i.e. over the two years it would take for changes to be reflected in organizational funding under the HSFR funding model) • Need to consider implications if cases become QBP cases in the future • NRS/rehabilitation patient categories currently available may not fit with the longer LOS of Slow Stream Rehab patients. Significant risk of funding loss by moving from per day funding in CCC to per case funding in rehabilitation. Loss of funding could impact all LHINs and HSPs that undertook changes where LOS does not fit current NRS grouping methodology. • Consider whether re-classifying will alter the CMI and cause further funding changes	
Data	• Single database supports planning, evaluation, budgeting, staffing • CCRS/MDS is time consuming and is not always the most appropriate tool for rehabilitation population whereas the FIM, provides more relevant data on the functional improvement of patients. • Single database will facilitate the monitoring and achievement of best practice targets		• Organizations that are unable to mobilize internal resources to align outcomes with ELOS targets and expected clinical outcomes will lose revenue. This could create a downward spiral where reduced resources make reaching standards more difficult, causing further revenue shortfalls. • The time requirement for collection of data would transfer from largely being the responsibility of nursing (i.e. nursing collect MDS in CCC) to largely being the responsibility of Allied staff (i.e. Allied staff largely collects NRS in rehabilitation), which has the potential to have an impact on Allied direct patient time	• If a frail/geriatric patient is appropriately placed in an inpatient rehab bed based in their functional need and requires a comprehensive geriatric assessment and/or is anticipated to required CCAC support upon discharge, the RAI MDS could be completed while in rehabilitation (in addition to NRS FIM) to inform the development of a cross continuum care plan (HSP/CCAC)

CLINICAL ISSUE for HSP	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
			• Need to consider the implications of patient complexities/ co-morbidities on LOS and RPG coding e.g. is NRS sensitive enough to capture complexities/comorbidities? • Classifications of QBP patients not necessarily consistent with previous rehab RPGs that it is replacing, so calculated funding may change significantly	

Section 3 - Risk Benefit Considerations for LHINs

CLINICAL ISSUE for LHIN	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
Best Practice Care Delivery	• May support development of centres of excellence with increased achievement of best practices			
Accountabilities	• May enable the development of clear accountabilities for outcomes if all rehabilitative care for a given population is delivered under a single database		• Potentially unrealistic LOS for patients admitted for rehabilitative care who would normally be considered medically complex and need slower rehabilitative care. • Potential to increase ALC in acute care due to increased demands for/flow through rehabilitation beds.	
Cost Effectiveness	• May support matching resources to beds to optimize the cost effectiveness and/or clinical outcomes • Providing patient's with increased opportunity for rehabilitative care services may drive treatment services to be responsive to patient's fluctuating functional needs, hence improving patient outcomes, which will lead to reconfiguration of total health expense and will yield cost reduction to the health system, while potentially improving patient experience through providing access to high quality rehabilitative care services at a local level • Initial investment directed towards enhancing rehabilitation intensity in rehabilitation for select	Initial investment directed towards enhancing rehabilitation intensity in rehabilitation for select population may result in decreased post discharge health care system expenses, as a patient may have achieved a higher level of functional outcome through intensified rehabilitative care services and a higher level of quality of life.	• Increased expense directed toward supporting rehabilitative care programs and best practice models • If the population that is being targeted for re-classification has high ALC in CCC, re-classification could potentially shift the ALC problem from CCC to rehab (which under HSFR would not be tolerated) • HBAM funding based on data that is 2 years old and not reflective of current state/ practice.	

CLINICAL ISSUE for LHIN	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
	population may result in decreased post discharge health care system expenses, as a patient may have achieved a higher level of functional outcome through intensified rehabilitative care services and a higher level of quality of life.			
Planning	• With beds designated according to actual use, it is assumed that better financial planning /allocations and decision making/planning can occur. • Rehabilitative care capacity planning will support evaluation of whether there is capacity within the system to serve patient needs OR if re-classification may be considered.		• Consider the impact of CCC/Rehab reclassification on respective funding envelopes for these bed types. Is there potential for the rebalancing across Rehab/CCC bed types regionally to have an impact on these funding envelopes provincially? Is there potential for the rehab funding envelope to be diluted if it is not adjusted with the bed reclassifications?	• Strategic provincial analysis of the impact of CCC/rehab bed reclassifications on funding envelopes with adjustments made as appropriate (MOHLTC)
Access	• May support more effective and efficient access to care by providing clarity and greater standardization of services.			
Incentives	• Better aligns implicit incentives in HSP funding with desired clinical outcomes • May incent integration of services as geographic bed capacity planning is undertaken vs within facility.			
Change Management		• Need to partner with referring sites/CCAC in areas with Coordinated Access to ensure the right patient is in the right bed (LHIN/HSPs)	• Monitoring/ auditing of implementation may be a challenge • Communication of change maybe challenging • Reporting systems need to be implemented to receive clinical outcome data/data in addition to data sent to CIHI • Implementation of re-designation process is within the auspices of the LHIN policy framework; however this needs to be communicated.	• Build a communication plan that address information needs at all stakeholder levels (LHIN/HSPs)
Human Resource Implications	• May support more effective and efficient use of HR as providers able to work to full scope and increase use of support personnel with greater critical mass.			

CLINICAL ISSUE for LHIN	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
Financial	• Under HSFR, each type of bed has a specific expectation of revenue stream (weighted cases for NRS and weighted days for CCC) that requires clear bed designation.		• Anticipated impact of HSFR is evolving and is largely based on a prior year's performance, hence a time lag before HSFR recognizes reclassification. HBAM projects future service levels (i.e. weighted cases and potentially weighted days in the future) which may not reflect actual future weighted volumes. • Need to consider the impact of reclassification on HBAM service variances. Reclassification to rehab could reduce service variances and negatively impact overall variances and hence affect overall HBAM funding. Lag may have negative impact in year beds are moved from CCC to rehab (i.e. in rehab, actual will be greater than expected (negative variance)). • The source of funds to support interim mitigation of re-classification will need to be identified (i.e. over the two years it would take for changes to be reflected in organizational funding under the HSFR funding model). i.e. The source of the incremental system dollars required to fund the increased therapy resources within re-classified beds to rehab will need to be identified • Need to consider implications if cases become QBP cases in the future • It will need to be determined how much of a role the LHINs need to play in playing an "intermediary" role between organizations and the MOHLTC. • NRS patient categories currently available may not fit with the longer LOS of Slow Stream Rehab patients. Significant risk of funding loss by moving from per day funding in CCC to per case funding in NRS beds. Loss of funding would impact all LHINs and HSPs that undertook changes where LOS does not fit current NRS grouping methodology.	• Mechanisms under HSFR to accommodate system changes will need to be developed so that HSFR does not become a deterrent to making patient-centered changes within CCC and rehab that may support improved patient outcomes and shorter lengths of stay (MOHLTC) • Clarify the role of the MOHLTC in addressing any potential funding impact to avoid a large disruptive change (MOHLTC) • Re-classification may not be one to one i.e may need to operate fewer rehabilitation beds with additional funds allocated towards operations (i.e. increased therapy) (LHIN/HSP) • Develop new RPG for slower stream rehab patients (MOHLTC) • Revise ELOS for current RPGs to better reflect /fund slower stream patients in rehabilitation (MOHLTC) • Develop trim point in rehabilitation for ELOS outliers (MOHLTC)

CLINICAL ISSUE for LHIN	BENEFITS OF RE-CLASSIFICATION	POTENTIAL ENABLING STRATEGY (and Lead)	RISKS OF RE-CLASSIFICATION	POTENTIAL MITIGATNG STRATEGY (and Lead)
Data	• Allows data for all patients receiving rehabilitative care to be captured in a single data base • Will support the development of clarity around ALC rates/days based on bed type, diagnostic code etc. • Will support development of a core clinical outcomes data set for rehabilitative care beds (rather than having two unrelated data sets i.e. FIM improvement over RPG ELOS in rehabilitation beds, RAI assessment every 90 days/goal attainment in CCC beds) • Single database will facilitate the monitoring and achievement of best practice targets			

4. PCRC Case Studies/Scenarios

The following case studies were collected between June and September 2014 from Ontario rehabilitative care system stakeholders. Responses are included where provided by representatives of the Rehabilitative Care Alliance LHIN Leads/HSP Advisory Committee from areas where re-classification activity was reported. LHINs reporting no re-classification activity include Mississauga-Halton, Hamilton Niagara Haldimand Brant, Central East and Central West. These case studies are organized based on the experiences of organizations that:

A. were considering re-classification
B. had completed re-classification
C. had collected dual coded data (including why it was collected and what story the data told)

A. LHINs Reporting Consideration of Re-classification

LHIN: North Simcoe Muskoka
Reported By: Cheryl Faber, Senior Manager, Health System Transformation, NSM LHIN
NOTE: Within the North Simcoe Muskoka LHIN there hasn't been any reclassification of CCC beds at this time. The results of this survey and the toolkit will prove to be valuable to our LHIN and Health Service Providers, based on the recommendations of our recent NSM LHIN Integrated Rehabilitative Care Model / System work (March 2014).

1. Please describe your experience related to re-classification:
NSM LHIN is considering reclassification given the fact that current CCC beds are under-utilized and the lack of rehab beds / capacity with increasing demand for rehab care within our LHIN, there is a current recommendations that were made in our March 2014 Integrated Model for Rehabilitative Care report. These recommendations all supported the development of an integrated rehabilitative care system in North Simcoe Muskoka, inclusive of patient populations, care pathways, out-patient services, staffing models, standardized level of services & eligibility criteria, central intake / system navigation, evaluation and measurement, standardized education / training, assessments, regional centres of excellence and the committee structure to support this work.
2. What data have you used to inform/support your decision-making regarding re-classification?
Nothing at this time, other than looking at CCC occupancy / utilization within our Regional / LHIN-Wide CCC System, as well as recent data on occupancy / utilization of rehab capacity in our LHIN.
3. In the context of your local experience, what questions/issues/challenges exist?
• Some hospitals in order to balance budgets are looking at bed closures to impact the bottom line, outside of "system-wide" work that has been agreed to when dealing with the operations of LHIN-wide / regional CCC beds and the potential to build capacity for regional rehab capacity. • The funding challenge for HSPs is key when you look at these types of reclassifications…especially as it compares to how much a hospital receives currently for a CCC bed as compared to how much they receive fo3235r Rehab beds…as well as the impact to funding visa vie the new QBP funding model.

4. Please describe any lessons learned from your experience related to considering/completing re-classification and/or collecting dual coded data that might be applicable to other organizations considering re-classification.
None to share at this time.

LHIN: South West
Reported By: Susan Warner, SW LHIN

1. Please describe your experience related to re-classification:

Background:

The CCC/Rehab bed realignment work is part of the CCC/Rehab stream of our Access to Care initiative**.** Access to Care is an approach to care focused on supporting people, specifically seniors and adults with complex needs, in their homes for as long as possible, with community supports. With an aging population, communities and health care partners are working together to support people:

- In the Community
- In the Hospital
- Accessing Special Services

Access to Care is changing care for seniors and adults with complex needs in order to support them in their homes for as long as possible. Change is focused on four areas:

- Home is the primary discharge destination for anyone entering the hospital
- Care in hospital is 'senior friendly'
- People access community and specialized hospital services using the 'coordinated access' process through the CCAC
- Services are located where they are needed

Drivers:

- Many people were waiting in hospital for long-term care and experiencing cognitive and functional decline during this time
- Many people had care needs that could have been better met elsewhere:
  - *37% of people in Complex Continuing Care beds**
  - 30% of people accessing Assisted Living services
  - 20% of people in Long-Term Care
- 1,000 more people could have benefitted from Adult Day Programs
- Services varied by region and provider:
  - Program elements, eligibility criteria, funding and client fee models
- *Inequitable geographic distribution of services; for instance, there were no CCC beds in the Grey Bruce geographic area of our LHIN**
- Ability to provide more intensive care for clients in the community and coordinated access due to legislative and policy changes

Considerations / Decision Making: **

The following principles were used to guide decision making:

- Data as the main driver, perspectives as input

- Appropriate utilization of resources
- Accounting for a projected significant increase in demand
- Geographic consideration to leverage economies of scale and caregiver expertise
- Improving geographical distribution of resources
- Aligning with the South West LHIN's Blueprint Vision 2022
- Considering LHIN priorities concerning minimizing additional capital requirements or human resource needs

Other considerations included benefits to:

- Residents of the South West LHIN – common eligibility criteria, equitable access geographically
- Affected communities – extensive municipal engagement
- Organizations – improve occupancy and weighted cases in CCC and Rehab, supporting more stability in funding
- System – alignment with Provincial Action Plan for Health and South West LHIN IHSP and Blueprint. Assists with reducing %ALC and aligns to HBAM expected cost by distributing volumes to match program/ cost capacity.

Who was involved?

- Leading to the decision, CCC/Rehab Steering Committee made the recommendations for Phase 1 and these were accepted by the Access to Care Core Operations Committee. These went forward to the South West LHIN Board of Directors who approved the following facilitated integration:
  - St. Thomas Elgin General Hospital (STEGH) will:
    - Close 15 CCC beds by April 30, 2014
    - Open 2 Rehab beds by April 30, 2014
  - Alexandra Hospital Ingersoll (AH) will:
    - Close 5 CCC beds by July 31, 2014
    - Close 4 additional CCC beds by October 31, 2014
  - Tillsonburg District Memorial Hospital (TDMH) will:
    - Close 6 CCC beds by January 31, 2015
  - Grey Bruce Health Services (GBHS) will:
    - Open 10 CCC beds in a staged fashion as follows:
      - 7 beds starting no later than November, 2014
      - 3 beds by February 28, 2015
- Extensive engagement occurred:
  - South West LHIN Hospital and CCAC Leadership Forum (hospital and CCAC CEOs)
  - South West LHIN Clinical Nurse Executive group
  - MPPs, town and county councils
- Integration planning occurred through coordinated meetings with CEOs of hospitals involved in the bed transfers. These were supported by the LHIN.

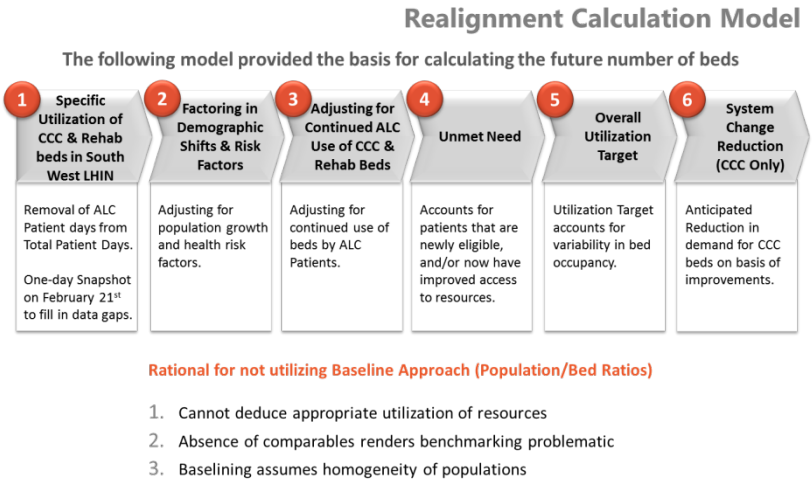
A sub group of leaders worked on a financial methodology, supported by the LHIN. The financial methodology influenced the timing of the opening of the new beds. Funds will be moved from the organizations closing beds to enable the new beds to open. The funding realignment will occur through the LHIN.

***key drivers for the CCC/Rehabilitation realignment work**
**** CCC/Rehab Reports with more background can be found on the South West LHIN website:**

Complex Continuing Care & Rehabilitation - Final Report May 2012
CCC/Rehab Bed Realignment Steering Committee Recommendations - June 2013
Restorative Care and Convalescent Care Final Report Apr 2013

2. What data have you used to inform/support your decision-making regarding re-classification?

Several data were used as input into the model used to calculate projected CCC and Rehab bed needs. The model follows:



Notes about the model:

- Utilization = occupancy – ALC, based on standard provincial definitions for ALC.
- Assumed a 3% adjustment for unmet need. An assumption was made by the Steering Committee that there could be an increase in demand for two reasons:
  i. There might be individuals not eligible under the old eligibility criteria that would now be eligible.
  ii. Redistributing CCC beds in the north part of the LHIN might lead to greater demand.
  - Population growth at 2% (based on Ministry of Finance Projections)
  - Risk factors set at 3% (based on previous data demonstrating level of health risk in the South West)
- System impact at -3% – this adjustment included taking into account recent and planned shifts (i.e. impact of Home First, system changes in Adult Day Programs, Assisted Living and Supportive Housing). The assumption made by the Steering Committee was that system changes such as Home First, Community Stroke Programs etc. would decrease the demand for CCC in the future.

Other factors considered:

- Size of projected bed shifts in relation to the overall size of the hospital
- Status of implementation of other Access to Care initiatives in the community
- Availability of LTC beds per population in the affected community
- Other quality initiatives that may change the need for CCC or Rehab beds
- Municipal and other stakeholder engagement and feedback

3. In the context of your local experience, what questions/issues/challenges exist?

- How to arrive at a consistent financial methodology to enable the bed shifts when hospitals were funded differently for these beds (some HBAM some small hospitals are not)
- How to ensure that a hospital would not be put at risk through bed closures/changes. Following is a summary of the cost benefit analysis:

Cost Benefit Analysis

The reallocation of beds and funding is for the most part cost-neutral. The primary benefits are: better access to the underserved Grey-Bruce area and enhanced, consistent CCC bed funding at all sites.

- Access to Care initiatives are reducing patient days in hospitals and ultimately providing cost savings – the CCC bed reallocation moves savings from redundant (closed) beds to fund new beds in Grey-Bruce. Savings would otherwise be used locally to bolster other hospital programs, but for large hospitals such as STEGH, the Health Based Allocation Model (HBAM) would ultimately recover savings for use elsewhere in the province (funding based on patient activity; reduced patient days reduces funding)
- The financial methodology CCC bed funding formula provides for a consistent level of support for CCC beds based on provincial average numbers for staffing, supplies, diagnostic and therapeutic services (allied health), etc. The new funding level per patient day is higher than the historical spending pattern of the Phase 1 hospitals. It is expected, however, that most patients will now require full CCC services as the number of ALC patients in those services will be reduced.
- The 10 new beds provided to Grey Bruce Health Services are funded at the direct cost level only, i.e. no allowance for additional administration and other indirect costs. The hospital has agreed to absorb the additional indirect cost burden. In the long run, the HBAM model should fund the provincial benchmark for both direct and indirect costs as the additional patient activity will generate HBAM full cost funding.

4. Please describe any lessons learned from your experience related to considering/completing re-classification and/or collecting dual coded data that might be applicable to other organizations considering re-classification.

- Having principles to guide the decision making regarding bed recommendations and principles to guide implementation was helpful.
- While support in principle was received from hospitals for the bed changes, it wasn't until the detailed planning began that the potential impact began to settle in.
- Being able to clearly articulate the benefits to residents of the South West LHIN, individual communities, organizations and to the system was helpful to build common purpose and to remind all of why this was occurring.
- All affected hospitals needed to work together to arrive at terms of the integration agreement.
- Required extensive and coordinated engagement with clear focused messages on why this was being done. This was supported by a robust communications plan.
    - All hospitals in the system through the South West LHIN Hospital and CCAC Leadership Forum (hospital and CCAC CEO table)
    - Internal hospital – staff and physicians
    - Community

  - Municipal/County
  - MPP
- Needed clarity around who was responsible for what communications and in what sequence because of the number of hospitals and communities involved.
- Integration process needed due diligence by all hospitals and by the LHIN. HR and other operational impacts needed to be considered.
- Having this as part of the overall Access to Care program in our LHIN was critical as the improvements in community capacity and ALC were realized through Home First and Adult Day Programs, Assisted Living and Supportive Housing as well as CCAC Coordinated Access for CCC/Rehab; all impacting the need for CCC beds in particular.
- Arriving at a consistent financial methodology in the absence of a clearly defined model of care and related expectations for service delivery levels and staffing resources was difficult.

LHIN: Waterloo Wellington
Reported By: Emmi Perkins, St. Joseph's Health Centre Guelph

1. Please describe your experience related to re-classification:

The Waterloo Wellington Rehabilitative Care Council recently completed a sizing exercise of the bedded levels of rehabilitative care in the region. This has been completed in follow-up to a comprehensive rehabilitative care system capacity plan that was completed in Spring 2012.
The 'WW In-patient Sizing Report' identified the following recommendations to support alignment with stroke best practices, the Rehabilitative Care Alliance's Definitions Framework, the Assess and Restore Guideline as well as other system enablers and directions.

1. The Rehabilitative Care Council supports the re-designation of 12 CCC beds to in-patient rehab beds (as proposed in the stroke integration business case) to support the best practice models of care and target Length of Stay (LOS) for stroke patients (within the estimated required 36 dedicated stroke inpatient beds). In practice, stroke patients have already been re-allocated from CCC to inpatient rehab beds. As an increased volume of stroke patients are utilizing inpatient rehab beds (i.e. increased demand), there is concern that there may not be sufficient capacity within inpatient rehab to meet the needs of other populations (as the "supply" of inpatient rehab beds has remained constant). This has the potential to impact both clinical outcomes (as populations who were previously served in inpatient rehab are displaced to CCC where fewer therapeutic resources are available) and/or system access (as patients may wait longer in acute care for an inpatient rehab bed). The specific population that is at risk of the previously mentioned displacement and reduced access is the geriatric population.
   Prior to making a decision regarding re-designation, additional information is required regarding the financial implications of re-designation in the context of HSFR. In order to develop a more comprehensive understanding of the clinical and financial implications of re-designating CCC to rehab beds, and in order to assess the needs and response of the target population (i.e. geriatrics), **it is recommended that a one-year pilot study be conducted to evaluate the following fundamental question:**

   Does the provision of a "geriatric rehab" therapeutic intensity to the current-state "Restorative Care" population result in improved patient outcomes, shorter lengths of stay, and "value for money"?

This pilot will also include an evaluation of the continuum of care. Specifically, the Rehabilitative Care Council will work with the Waterloo Wellington Community Care Access Centre (WWCCAC) to identify indicators that will support a comparative analysis of the costs and patient outcomes associated with delivering a geriatric model of care within an Assess and Restore framework, versus the costs and patient outcomes associated with delivering care to this patient population in their home.

The results of the planned pilot evaluation will inform the development of a longer term plan to deliver this critical and provincially recommended level of rehabilitative care.

2. What data have you used to inform/support your decision-making regarding re-classification?

An analysis of the following local factors has been considered:

1. Current Resources
2. Current Utilization (including Acute ALC, LOS, Occupancy)
3. Application of Target LOS
4. Anticipated changes in demand for these services
5. Unmet Need

Additionally, information regarding the draft Assess and Restore Guideline, the RCA Definitions Framework and HSFR have been considered. Specifically, the WW Rehabilitative Care Council has sought direction from local decision support/finance and provincial subject matter experts to ensure comprehensive impact analysis of HSFR on local decision making.

3. In the context of your local experience, what questions/issues/challenges exist?

Lack of resources to fund pilot study including dual coding (collection and analysis)
Competing priorities

4. Please describe any lessons learned from your experience related to considering/completing re-classification and/or collecting dual coded data that might be applicable to other organizations considering re-classification.

Nothing at this time.

LHIN: North West
Reported By: Susan Pilatzke, Senior Director, Health System Transformation, NWLHIN

1. Please describe your experience related to re-classification:

NW LHIN is considering reclassification. There is strong demand for post-acute inpatient and outpatient programs related to Rehabilitative Services and Programs in Thunder Bay and across the region. Historically there has been one site that provides inpatient post-acute care services/programs inclusive of Complex Continuing Care (CCC) with a breakdown of 60% of the CCC bed capacity in the City of Thunder Bay, 40% of the CCC bed capacity outside of the City of Thunder Bay and 100% of all designated inpatient rehabilitation beds located in the City of Thunder Bay. When implemented effectively, these services and programs improve the long-term clinical outcomes for patients.

It is recognized that the paradigm is shifting and the post-acute care model of service delivery is undergoing significant reform in the province of Ontario through implementation of quality based procedures and health system funding reform. The need for change in the North West LHIN has been identified and some work has been undertaken to better understand the current state. It is anticipated that coordination and continuity of care will be strengthened and health outcomes improved by creating an integrated model of care for post-acute service delivery (Rehabilitative Services/Programs) across the North West LHIN.

2. What data have you used to inform/support your decision-making regarding re-classification?

The review will consider existing North West LHIN data, reports or analysis and will draw on relevant research and findings on post-acute care settings from other jurisdictions (inpatient and outpatient rehabilitative and complex continuing care services/programs). Additionally a comprehensive current state analysis has been completed by the current post-acute care provider within the NWLHIN. We are in the process of reviewing this document.

3. In the context of your local experience, what questions/issues/challenges exist?

With approximately 47% of the provincial land mass and 231,000 people (2.1% of Ontario population), the widely dispersed populace and large geography of the North West LHIN present both challenges and unique opportunities to develop innovative service delivery models to meet local needs. Although a primary strategic direction of the North West LHIN is the provision of services as close to home as possible, it is recognized that due to the economies of scale required to achieve efficiencies, this is sometimes difficult. Innovative solutions will be required to ensure that post-acute services are accessible and standardized across the North West LHIN inclusive of rural and remote northern areas of Northwestern Ontario.

4. Please describe any lessons learned from your experience related to considering/completing re-classification and/or collecting dual coded data that might be applicable to other organizations considering re-classification.

At present we have not reclassified CCC/Rehab beds in the NWLHIN. This step is being considered for the 2014/15 fiscal year. Some key elements include capacity to support rehab services in small communities outside of Thunder Bay and in rural remote fly in First Nation communities; access to HHR to deliver the services, reporting requirements including licenses that at times are difficult to maintain when a site has a small number of CCC beds in use; innovative use of technology to deliver the care according to the definitions established provincially and ultimately siting and sizing of Rehab/CCC beds in accordance with the North West LHIN Health Services Blueprint Model. We would like to understand the key learning from other LHINs that have reclassified or dually coded data and the types of operational changes that were implemented to effect system improvements.

LHIN: ESC
Completed By: Helen Johnson, ESC LHIN Rehabilitation Network Lead

1. Please describe your experience related to re-classification:
In the ESC LHIN we are following this topic closely to decide if we should be considering re-classification. As part of the ESC LHIN Rehabilitation System Strategic Plan, we have been undertaking an evaluation of our current system of bedded rehabilitative care resources to understand if we have sufficient capacity for implementation of best practices. To understand if current needs are being met (and if future needs will be met), we have undertaken predictive modeling exercise with the help of a consulting firm. Our predictive model is built on current system bed utilization as a base case, and allows for analysis of various alternative scenarios and how they might impact on bed numbers. The model has been aligned with the draft RCA Definitions Framework for Bedded Levels of Rehabilitative Care. Concurrent to this work are the development of cross continuum care pathways for patients with stroke, hip fracture, and frail seniors/medically complex patients. We do not have any sites in our LHIN where dual coded data has been collected.
2. What data have you used to inform/support your decision-making regarding re-classification?
Our Rehab Bed Planning Model was built with utilization data from all the relevant data bases (NRS, CCRS) linked to the DAD, as well as ALC days and other data. We have yet to review data on case weights, costs and funding but will be undertaking this in the near future.
3. In the context of your local experience, what questions/issues/challenges exist?
In our local discussions we continue to have questions around funding – where will the funding be available to increase the staffing? Comorbidities are not accounted for well in the current NRS – i.e. they do not add to the weighting and the length of stay Need to figure out a way to factor in comorbidities into how rehab cases are weighted in the NRS, similarly to case weighting in acute care; two patients with the same RPG may have different tolerance for rehab activity due to different comorbid conditions which could impact the LOS

4. Please describe any lessons learned from your experience related to considering/completing re-classification and/or collecting dual coded data that might be applicable to other organizations considering re-classification.
n/a

B. LHINs Reporting Having Completed Re-classification

LHIN: Central
Reported By: Winston Cheuk – Director of Clinical Utilization, Mackenzie Health

1. Please describe your experience related to re-classification:
Re-classification has been completed. The driver was to provide the adequate number of rehab beds (stroke) based on the stroke flow best practice. The decision was based on the number of stroke patients admitted to Mackenzie Health (a District Stroke Centre in Central LHIN) and the projected required rehab capacity based on the stroke flow best practice.
2. What data have you used to inform/support your decision-making regarding re-classification?
Stroke volume, percentage distribution of RPGs, recommended LOS for each RPG, actual LOS in MH
3. In the context of your local experience, what questions/issues/challenges exist?
Changes to H-SAA target Changes in acuity on the unit Staffing resource – particularly PT, OT, SLP in order to achieve LOS target Set out new admission and discharge criteria
4. Please describe any lessons learned from your experience related to considering/completing re-classification and/or collecting dual coded data that might be applicable to other organizations considering re-classification.
Senior leadership endorsement Clear demand analysis LHIN endorsement Available resource to cope with increase demand for rehab workers

LHIN: South East
Reported By: Benedict Menachery, SELHIN

1. Please describe your experience related to re-classification:
Re-classification has been completed: • in response to changing demographics – particularly population growth and aging as it impacts forecast demand for CCC vs Rehab service • to alleviate pressures in the demand for rehabilitation particularly in the context of little pressure in the CCC sector
2. What data have you used to inform/support your decision-making regarding re-classification?
In order to change the classification of beds, there are a number of issues the LHIN must consider before approving the application. As such we require the hospital to submit a business case detailing : • The rationale for the change in the classification, including an articulation that the re-classified beds will not be needed in the immediate future for the previous purpose. The hospital is required to present a compelling case for the reclassification, which may include such information as the changing demographics of its population or a need to alleviate pressures in other areas.

- Cost benefit analysis to determine financial implications addressing such issues as: whether the reclassification will result in increased hospital costs; whether the hospital will be able to manage within its allocation; whether there will be capital costs associated with the reclassification?
- Impact on PCOP?
- Service availability and labour relations impact detailing such issues as: whether there are sufficient health human resources to manage the reclassification; and whether the reclassification will have an impact on labour relations or labour agreements?
- Potential HSFR funding impacts resulting from the reclassification

3. In the context of your local experience, what questions/issues/challenges exist?

- Differentiate cost of restorative care versus complex continuing care. Variation among providers.
- Determining HSFR impact
- Determination of Impact on PCOP.
- Validating improvement in patient outcomes as a result of the reclassification

C. LHINs Reporting the Collection of Dual Coded Data

LHIN: North East

Reported By: Kari Gervais, VP, Clinical Services and Chief Nursing Executive, St. Joseph Continuing Care

1. Please describe your experience related to re-classification:

St. Joseph's Continuing Care Centre of Sudbury has been completing dual coding for the past year. The intent of the dual coding was to gather data required to attempt to address the long-standing question of whether our programs would be more appropriate with a rehab designation versus a CCC designation. We provide primarily slow-paced rehabilitative care in our 64-bed class G hospital. We would prefer to be able to complete the CCRS and the NRS on all of our patients but simply do not have the resources to do so. We started our coding project with the knowledge that we would only be able to capture 20% of our population in one year using current resources. One-time funding was an option presented to the NE LHIN, but funding was not available through that avenue. We are nearing the end of our year and look forward to analyzing our data.

2. What data have you used to inform/support your decision-making regarding re-classification?

We have identified a significant lack of information that is available to help us make an informed decision. We are particularly uncomfortable with the lack of knowledge related to how reclassification could impact funding through HBAM. To date, we have information from the CCRS, and a 20% sample size of patients admitted in the last year who were also assessed using the NRS. We have not been able to compare and analyze the data gathered from the two databases but will be working with CIHI to complete this work. Unfortunately, CIHI will only be able to tell us how our NRS data compares with other rehab programs, and cannot comment on the impact to funding.

3. In the context of your local experience, what questions/issues/challenges exist?

As mentioned, the lack of coordinated effort related to dual-coding is a significant challenge. We do not have the resources to dual-code on all patients, and even the 20% we are currently coding is a significant challenge. We have been unable to secure one-time funding from the NE LHIN and simply do not have room in our budget to up-staff to complete the coding.

LHIN: Champlain
Reported By: Kathy Greene, Director of Decision Support, Bruyère Continuing Care

1. Please describe your experience related to re-classification:

Bruyère collects limited dual coded information for a sub-set of its Restorative Care Service in Complex Continuing Care (CCC). CCC collects and submits CCRS-MDS data as well as collecting FIM data on 18 Neuroscience beds which are low intensity long duration (LILD) rehab beds for stroke patients with an admission FIM below 40. FIM data is not submitted to CIHI for these LILD patients. FIM data is collected every second week on LILD patients for review at Inter-professional clinical rounds. NRS data (which includes FIM) is collected on High Intensity Stroke Rehab (HISR) patients as per NRS standards and is submitted to CIHI.
FIM data collected on LILD patients is used for clinical decision making by the treating team-

- Tracking patient progress during his/her LILD rehab stay for discharge planning purposes
- Goal setting of functional skills (i.e. transfers)
- Determining appropriateness for transfer to High Intensity Stroke Rehab (HISR)

FIM data is used to ensure admission criteria between LILD and HISR are followed as well as to track patient progress in each stroke service. Dual coded FIM data was used to create a patient profile for HISR and LILD as well as monitor metrics on patient progress while in the program.

2. What data have you used to inform/support your decision-making regarding re-classification?

Not applicable to Bruyère.

3. In the context of your local experience, what questions/issues/challenges exist?

HISR and LILD rehab services are not within the same facility at Bruyère. Dual coding requires two separate clinical teams to be trained in the coding of FIM with the LILD team also needing to collect MDS data on each patient. It is a challenge to collect dual coded data as it requires additional staff training as well as ongoing data quality monitoring.

Collecting FIM data for the LILD patient population has been useful towards determining when a patient is ready to transfer to HISR or conversely when a plateau has been reached and discharge planning needs to proceed.

4. Please describe any lessons learned from your experience related to considering/completing re-classification and/or collecting dual coded data that might be applicable to other organizations considering re-classification.

Ensure your organization has the necessary front-line managerial support and educational infrastructure to train clinicians in the utilization of distinct coding systems. Regular staff turnover necessitates regular MDS & NRS training (3-4x per year).

Ensure clinicians have the necessary time to perform the dual coding as part of their day to day work activities. If at all possible ensure the coding is electronically completed.

Ensure optimal quality of the dual coded data through regular validation to ensure its usefulness for analytical purposes. Ensure aggregate data is brought back to the clinical team so they can see how it is utilized to understand its overall value.

LHIN: Toronto Central

Reported By: Nancy Jones, Professional Practice Chief – Physiotherapy, Program Manager, Specialized Geriatric Services, Baycrest

1. Please describe your experience related to re-classification:

At Baycrest, we collect NRS data, including the FIM, on all patients admitted to our rehabilitation program. This includes our High Tolerance (HT) a 32 designated rehab bed unit as well as our Slow Stream (SSR), a 30 designated CCC bed unit. We have NRS data on patients admitted to the SSR unit going back to the opening of this unit in 2011. Of note – the High Tolerance program is designed to provide a multi-disciplinary rehab approach with a frequency of 5 day per week and an intensity of 2-3 hrs. of direct therapy daily. Conversely, the SSR program is based on 3 day per week frequency and 30 – 60 minutes/day of therapy.

The original purpose of the "dual coding" was to ensure we were indeed triaging patients to the right bed. It was the intent of the SSR unit to accommodate those patients who met the rehabilitation criteria for an inpt stay but were deemed to have a lower tolerance for therapy and to have a longer than expected stay – thus meeting the definition of a low tolerance long duration candidate.

In order to determine if our triaging was accurate, the following indicators were deemed as indicative:

1) Overall Avg Admission FIM score
2) Avg Admission Motor score
3) Avg Admission Cognitive Score
4) Avg Discharge FIM scores
5) Avg FIM change – motor and cognitive
6) Age
7) RPG
8) LOS
9) Discharge Destination

We also looked at metrics such as Wait Time to Rehab, number of co-morbidities and results of standardized outcome measures i.e. TUG, 2 min walk, Berg.

An analysis of the data for 13-14 has shown us difference between HT and SSR in the following areas:

1. Higher Avg Admit FIM scores in HT – avg diff 23 points
2. Higher Avg Motor FIM scores in HT– avg diff 18 points
3. Higher Avg Adm Cognitive Scores in HT – avg diff 6 points
4. Avg D/C FIM scores = Higher Discharge FIMs in HT – avg diff 14 points
5. RPGs – majority of SSR pts. did fall into the lowest RGP within their Rehab Client Grouper
6. LOS – significant difference here – HT = 32 days; SSR = 85 days
7. Discharge Destination – greater % of HT went home – diff of 22%
   and greater % in SSR went to LTC or back to acute settings (11 and 5% diff respectively)

Factors that were not significantly different:

1. Age - very similar between the 2 units – if fact slightly higher % of 81-90 yrs age group in High Tolerance
2. Pre-living environment/support – similar % living alone – 36% HT vs. 32% SSR

3. Pts. in both units showed very little change in their Cognitive FIM scores during their stay – avg 1 and 1.5 points.

Interestingly, the SSR pts. showed a greater avg FIM score change over time – HT =16 vs. SSR = 26 although FIM efficiency is lower for SSR secondary to longer LOS. This does indicate that these pts. do have potential for functional change and respond favourably to therapeutic interventions.
So the question now becomes: *Would they be able to realize these types of change more quickly in a more intensive therapy environment?*

Wait times – the data does indicate SSR pts have a longer wait time before admission – this may be due to a number of factors:

1. Medically more complex – requiring a longer stay to treat/ stabilize in acute care
2. More difficult pts.to place in rehab programs – rehab waiting for more info, longer time to medically stabilize, don't have the nursing resources to care for certain conditions
3. Concern for ability of these pts. to return to pre living environment – possible ALC-LTC

Another interesting finding: it appears that we have 3 distinct groups on our SSR based on our data and pt descriptors. They would fall into one the following categories based on the RCA Bedded Levels of Rehab Care:

- Rehabilitation
- Restorative /Convalescent Care
- Short Stay Medically Complex – CCC

2. What data have you used to inform/support your decision-making regarding re-classification?

We are not looking at re-classification at this time. However we are looking at that cohort of pts. in SSR who have similar characteristics to HT pts., those is some of the Medically Complex and in our Ortho RPGs, where the LOS are more similar, to determine if we can triage more of these pts to HT. The goal would be to realize shorter LOS with similar functional outcomes for these pts.

We are also continuing to look for any other characteristics that correlate well with LOS and positive outcomes that we may be able to screen for at triage.

3. In the context of your local experience, what questions/issues/challenges exist?

Our basic tenant in accepting and triaging pts. is that all pts. should be placed in a program that maximizes their rehab potential – this includes providing the appropriate level and intensity of therapy based on evidence, preferably on a daily basis, in an environment that utilizes all the skills and abilities of an interprofessional rehab team operating from a rehab focussed philosophy.

This being said, we are still faced with the challenge of either

a) Increasing resources on the SSR to match HT to ensure greater therapy frequency (5Xper wk.)
b) Triaging more effectively those pts who will benefit the most greater frequency and more focused therapy interventions and admit those pts to HT

Attaining b) will entail increasing our ability to effectively re-route those pts. who do not need an inpt level of rehab services (can safely be treated at home or in the community). In this way we can increase our capacity

to take on those patients who do need an inpatient stay.

We also face the challenge of ensuring that we have the necessary nursing resources and skill level to care for patients who are more complex medically. As we stream pts. to the community we will have potentially higher needs patients in the inpatient setting and must be able to provide the care at the level they require.

In terms of funding, we, like our peers, are faced with uncertainly in regard to the HSFR and its impact on our rehabilitation services within our current and proposed future models.

4. Please describe any lessons learned from your experience related to considering/completing re-classification and/or collecting dual coded data that might be applicable to other organizations considering re-classification.

We have found that "dual coding" has helped us greatly in understanding our rehab population, ensuring that they are indeed realizing functional recovery, and tracking our abilities to improve care and outcomes. We will continue to gather this information as we implement improved rehab candidacy criteria, admission processes and triage strategies, ensuring success for our pts.' goal of returning to their homes and communities.

LHIN: TCLHIN

Reported By: Peter Nord, VP, CMO and Chief of Staff Providence Healthcare, Toronto; Jim Elliott, CFO, Providence Healthcare, Toronto; Bill Manson, Senior Director, TCLHIN,

1. Please describe your experience related to re-classification:

Providence Healthcare (Toronto), together with the Toronto Central LHIN made a significant (47 bed) re-classification of CCC to Rehabilitation beds as of July 1st, 2014.

Background: In January 2010, Providence approved a new five year Strategic Plan '*Time to Shine'*. A key component of this dynamic and responsive strategy was its focus on inpatient and outpatient flow and building formal partnerships with acute care and community organizations to manage these flows and to alleviate ALC pressures at Providence and in acute care.

Demonstration Project: A formal 4 year Demonstration Project, supported by the Toronto Central LHIN, resulted. The central component of the project was a demonstration that patient flow from acute into rehabilitation and complex continuing care beds could be improved by providing rehabilitation to 'low-tolerance' patients who do not meet the admission criteria for regular rehabilitation due to their inability to tolerate several hours of active rehabilitation therapy on a daily basis. The specific objectives of the Demonstration Project were to:

- Admit patients sooner from acute care in order to start rehabilitation without delay,
- Maintain the annual number of patients cared for, with fewer inpatient beds
- Return more patients to home
- Reduce ALC days at Providence
- Improve patient satisfaction
- Operate responsibly within financial parameters

In order to measure the rehabilitation outcomes of the project, dual coding (i.e. completing both NRS and CCRS coding for the each patient in a CCC bed) was expanded to all non-palliative patients by the third year of the project. The Demonstration Project ended on March 31, 2014 with outstanding results for each objective of the project (Table 1).

As the number of patients being dual coded expanded during the project, Providence made the strategic and operational decision in fiscal 2012/13, to manage all non-palliative patients as if they were rehabilitation patients, and to measure organizational performance based on the quality and patient flow measures associated with the NRS grouper. With the successful conclusion of the project in March 2014, it made strategic, operational and system sense to proceed with a formal request to the TCLHIN to reclassify 47 (approx. 40%) of the non-palliative CCC beds at Providence.

Providence is monitoring another tranche of CCC beds for possible reclassification in the future if NRS and HSFR are adapted to include specific RPGs for "low tolerance" rehab patients consistent with the draft recommendations of the Rehabilitative Care Alliance.

2. What data have you used to inform/support your decision-making regarding re-classification?

As presented in Table 1, in the 4 years following TCLHIN approval of the Pilot and Demonstration Projects, Providence has reduced the number of staffed CCC beds by 60 (from 218 to 158 before the reclassification) while:

- increasing the number of admissions from approximately 1,900 per year to in excess of 2,600 per year;
- maintaining occupancy at approximately 92%;
- increasing the percentage of patients discharged home to over 80%;
- reducing the number of ALC patients by almost 70%;
- reducing length of stay by 45%;and
- maintaining the average admission FIM score for patients in CCC beds and lowering the average admission FIM score by 7% in rehab beds.

The results of the Demonstration Project provided the evidence to make a compelling Business Case to the TCLHIN for reclassification of 40% of Providence's non-palliative CCC beds. This represented those CCC beds that were, on average, already achieving benchmark rehab ALOS with a slow stream rehabilitation patient population. The beds affected were split almost equally between the stroke/neuro and geriatric populations at Providence. The ALOS for slow stream orthopaedic patients was generally far greater than benchmark RPG ALOSs and very few beds were reclassified for this program.

The Business Case to the TCLHIN highlighted:

- the successful clinical results of the Demonstration project;
- the alignment of the proposed reclassification with the TCLHIN's Best Practices for Stroke Rehabilitation and an innovative TCLHIN Stroke/Msk Business Case initiative;
- the fact that there would be no additional cost impact as slow stream rehab patients in CCC

beds were already receiving the maximum amount of therapy that they could tolerate;
- consistency with the emerging Rehabilitative Care Alliance definition of Rehab (includes slow stream patients);
- consistency of the reclassification with the recommendations of the December 2013 Auditor General's Value for Money Report on Inpatient Rehabilitation and the Ontario Senior's Strategy;
- that acute care partners would see no change in Providence's response to Rehab/CCC referrals from them;
- potentially favourable revenue impacts as a result of differential rates for Rehab beds and HBAM weighted case funding for this slow stream population;
- that there were no capital costs associated with the proposed reclassification; and
- that NRS coding to CIHI for the reclassified beds was ready to be initiated;

3. In the context of your local experience, what questions/issues/challenges exist?

As noted above, the lack of slow stream specific patient groups within the RPG grouper could negatively impact future funding under HSFR if all slow stream beds were reclassified.

4. Please describe any lessons learned from your experience related to considering/completing re-classification and/or collecting dual coded data that might be applicable to other organizations considering re-classification.

The most significant lesson learned was that change of this magnitude requires extensive planning and a rigorous approach to change management. Providence followed the LEAN methodology in designing and implementing this flow project over a 2 year period before embarking on the Demonstration Project with the TCLHIN. Significant effort was invested in developing strategies to ensure that the improvements to flow will be sustained.

The investment in "dual coding" provided essential information for measuring project outcomes and to support the Business Case for bed reclassification. During the course of the Demonstration Project, Providence's operational focus gradually shifted to the NRS grouper for all non-palliative patients.

Our success with this project is largely due to the trust between the Providence and TCLHIN leadership teams and the depth of their mutual understanding of the value and impact of re-classification on many aspects of the organization and local health system.

5. What measures are being (or could be) used to evaluate the effectiveness of the re-classification?

Providence continues to measure performance based on the NRS grouper and its associated quality indicators together with the other scorecard measures from Table 1.

Table 1 - Transformation by Design Project - Outcomes

	FY 2008/09 Actual Pre Transformation	FY 2009/10 Actual Base Year	FY 2010/11 Actual Pilot Project	FY 2011/12 Actual Demonstration Project	FY 2012/13 Actual Demonstration Project	FY 2013/14 Forecast
Admissions	**1,759**	**1,905**	**2,074**	**2,168**	**2,231**	**2,627**
Current Ratio	**1.5**	**.86**	**.93**	**1.29**	**1.6**	**1.8**
CCC Beds	**260**	**218**	**210**	**193**	**175**	**158**
Rehab Beds	**87**	**87**	**87**	**87**	**87**	**87**
ALOS (Rehab & CCC)	**76 days**	**62.9**	**55.3**	**47.6**	**42.3**	**34.6**
Occupancy	**92.6%**	**91.7**	**92.0**	**93.0**	**94.0**	**92.3**
Discharged Home	**69.3%**	**73.1**	**78**	**78.3**	**80.5**	**81.0**
Average ALC Patients	**91**	**64**	**31**	**31**	**23**	**21**
Admission FIM (for rehab beds)	**78.3**	**78.6**	**78.6**	**79.1**	**75.1**	**73.3**
Discharge FIM (for rehab beds)	**99.7**	**102.3**	**102.0**	**105.0**	**103.2**	**101.67**
Admission FIM (Transformed Units – CCC beds)	**n/a**	**n/a**	**n/a**	**63.5**	**63.9**	**63.0**
Discharge FIM (Transformed Units – CCC beds)	**n/a**	**n/a**	**n/a**	**88.2**	**91.0**	**90.23**

5. National Rehab System (NRS) Grouper – 2014-15 Provincial RPG Cost Weights

Source: Canadian Institute for Health Information (CIHI)

Note: Cost Weights are expected to change from year to year

REHAB GROUP COST WEIGHTS		
Rehab Group	**RPG**	**Cost Weight**
11 - Stroke	**1100**	**2.4043**
	1110	**2.1061**
	1120	**1.4695**
	1130	**1.2389**
	1140	**1.9289**
	1150	**0.7309**
	1160	**0.5668**
12 – Traumatic Brain Injury	**1200**	**7.0583**
	1210	**4.594**
	1220	**2.7101**
	1230	**2.673**
	1240	**1.6146**
	1250	**1.2502**
13 – Non - Traumatic Brain Injury	**1300**	**2.9967**
	1310	**1.5495**
	1320	**1.2429**
	1330	**0.8141**
14 - Neurological	**1400**	**2.2371**
	1410	**1.5058**
	1420	**0.9074**
	1430	**0.5427**
15 - Traumatic Spinal Cord Injuries	**1500**	**6.067**
	1510	**4.2717**
	1520	**4.01**
	1530	**1.7664**
16 - Non-Traumatic Spinal Cord Injuries	**1600**	**3.0728**
	1610	**1.7545**
	1620	**1.9202**
	1630	**1.1476**
	1640	**0.9905**
17 – Amputation, Not Lower Extremity	**1700**	**1.384**
	1710	**0.7384**

REHAB GROUP COST WEIGHTS		
Rehab Group	**RPG**	**Cost Weight**
18 – Amputation, Lower Extremity	**1800**	**1.9614**
	1810	**1.4126**
	1820	**1.6823**
	1830	**1.124**
19 - Osteoarthritis	**1900**	**0.8123**
	1910	**0.3271**
20 - Rheumatoid Arthritis & Other Arthritis	**2000**	**0.8271**
	2010	**0.632**
21 - Pain	**2100**	**0.8487**
	2110	**0.4161**
22 - Fracture of Lower Extremity	**2200**	**1.1494**
	2210	**1.167**
	2220	**0.9357**
	2230	**0.8368**
	2240	**0.7014**
	2250	**0.6157**
23 – Replacement of Lower For hips and knees, this is a QBP and subject to funding restrictions	**2300**	**0.813**
	2310	**0.4726**
	2320	**0.5661**
	2330	**0.3811**
	2340	**0.3339**
	2350	**0.2829**
24 - Other Orthopedic	**2400**	**1.0996**
	2410	**0.7115**
	2420	**0.8287**
	2430	**0.4399**
	2440	**0.4072**
25 - Cardiac	**2500**	**1.0211**
	2510	**1.8564**
	2520	**0.4593**
	2530	**0.444**
	2540	**0.5275**
26 – Pulmonary	**2600**	**0.8389**
	2610	**0.7265**
	2620	**0.7986**

REHAB GROUP COST WEIGHTS		
Rehab Group	**RPG**	**Cost Weight**
	2630	**0.6298**
27 - Burns	**2700**	**1.4128**
28 - Major Multiple Trauma, Other Multiple Trauma & Major Multiple Fracture	**2800**	**1.8512**
	2810	**0.9765**
	2820	**1.4069**
	2830	**1.1636**
	2840	**0.9192**
29 - Major Multiple Trauma with Brain or Spinal Cord Injury	**2900**	**2.7268**
	2910	**1.1306**
	2920	**0.9173**
30 - Vent Dependant Respiratory Disorders	**3000**	**0.4499**
31 - Other Disabilities	**3100**	**1.2253**
	3110	**0.8555**
	3120	**1.0389**
	3130	**0.8121**
	3140	**0.6688**
Source: Canadian Institute for Health Information (CIHI)		

6. HBAM Calculator

The following estimate will support an approximation of the likely impact of HSFR funding for non-QBP groups of patients/beds that are being considered for re-classification from CCC beds to Rehab beds:

1. Calculate CCC weighted days * hospital expected cost per weighted day for current population of patients = $x
2. Calculate the estimated future number of Rehab weighted cases in the reclassified beds (likely from dual coding information) * hospital expected cost per weighted case = $y

If y-x is near zero or above – this is a favourable result i.e. supportive of re-classification

Note 1: The above assumes that HBAM's "expected level of service" calculation approximates the hospital's "actual level of service". This assumption needs to be validated as part of each reclassification decision.

Note 2: Need to consider the impact of ~18 month time lag between HBAM data collection and impact on funding announcements

7. Potential System-Level Data Analysis to Support Re-Classification Considerations

The following provincial level analyses may provide further direction to LHINs / HSPs who may be considering reclassification of CCC/Rehab beds:

System-Level Questions		Potential Approach to Data Analysis	Source of Data	Potential Impact on Decision Making
How much rehabilitation is currently happening in CCC beds?		Estimate the weighted cases through dial coding and LOS of all CCC cases with a rehab admission RUG score (RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB)	CCRS	May help to quantify the current cost (and outcomes) of rehabilitative care that is currently being provided in CCC and the potential system level impacts of re-classification
What are the characteristics of patients who are currently in CCC beds who are receiving therapeutic intervention to achieve functional goals and who are expected to be discharged to the community once those goals are accomplished (i.e. those placed within Special Rehabilitation RUG categories upon admission to CCC) and for whom the provision of higher intensity therapy will result in improved outcomes and a LOS within the NRS estimated average LOS?		Collect/review available, relevant dual coded data Consider the dual coding experiences of Bruyere, Baycrest and Providence Case Studies	RCA PCRC Toolkit "PCRC Case Studies/Scenarios" (www.rehabcarealliance.ca)	May support referrers in the identification of patients who would benefit from higher intensity rehabilitative care (i.e. in a rehabilitation bed) versus those who are most appropriately served in a less intensive level of care. May help to quantity the need for additional capacity in rehabilitation care beds and/or support planning of the number of beds to be considered for re-classification.
What are the characteristics of CCC patients who currently have a CCC LOS within the NRS estimated average LOS?				
What are the potential system impacts of re-classification of CCC/rehab beds on HSFR?	What impact would re-classification have on ALC in acute beds?	Time to Access CCC beds vs rehabilitation beds – Acute Care ALC Days for patients d/c to CCC for rehabilitaion vs Acute ALC days for patients d/c to inpatient rehabilitation by LHIN. Alternatively, % acute ALC by destination	DAD	May support a comprehensive understanding of the broader system implications of reclassification and/or a strategic approach to planning rehabilitative care system capacity based on broader system needs/pressures.
	What impact would re-classification have on ALC in inpatient rehabilitative care beds?	Cross map # of rehabilitation beds per 100,000 & number of CCC beds per 100,000 compared to acute ALC days for each	OHA (# of beds), LHIN population profiles, DAD (ALC)	
		Identify what level of care/discharge destination patients are waiting for who are designated ALC in CCC (stratified by LOS < 30, 60, 90)	Access to Care	

8. Re-classification Evaluation Criteria

The following measures are suggested to support evaluation of the impact of re-classification:

Suggested Measures (by RPG, compared to baseline performance)	**Goal**
Outcomes for services/conditions utilizing rehabilitation & CCC beds	Improved FIM efficiency
Length of stay in rehabilitative care beds	Average lengths of stays approaching HSFR's ELOS or QBP targets
Total length of stay (acute + post-acute)	Reduced total LOS
Occupancy rates in rehabilitative care beds	Meet HSAA occupancy targets
Acute care ALC rates for bedded levels of rehabilitative care	Reduced acute care ALC rates for bedded levels of rehabilitative care without an offsetting increase in acute care ALC rates for CCC
Rehabilitative care ALC rates by discharge destination	No increase in rehabilitative care ALC rates
Discharge dispositions from rehabilitation/CCC	Increased discharges to pre-morbid disposition
30 and 90 day acute care readmission rates (i.e. admitted to acute within 30 and 90 days after discharge from bedded levels of rehabilitative care)	Reduced readmission rates
Admissions to long term care from bedded levels of rehabilitative care	Reduced admissions to LTC from bedded levels of rehabilitative care and 6 months post discharge
Patient/Caregiver Experience	Improved Patient/Caregiver Experience
Financial impact on the organization	No negative financial impact

Any initiative to re-classify beds will need to consider the significant health care system transformation occurring in Ontario specifically related to the following areas that impact Post-Acute Care. Accordingly, additional indicators to evaluate the effectiveness of re-classification activities could be derived from these areas:

- Quality Based Procedures Expert Panel work
- Health Quality Ontario initiatives
- Ontario Renal Network directions
- Ontario's Seniors Strategy
- Physiotherapy Reform
- Provincial Resource Matching and Referral initiative
- Health System Funding Reform
- Ontario Stroke Network directions
- Palliative Care Planning in the Province
- Rehabilitative Care Alliance work
- Orthopaedic Capacity Planning
- Health Links
- Provincial Reports including but not limited to: the Drummond Report, the Walker Report, the Baker Report and Dr. Sinha's Senior Care Strategy.
- Policy direction and revisions to Assisted Living, Convalescent Care and Long-term Care Services
- Role change for the Community Care Access Centre with respect to Complex Continuing Care and Rehabilitation

Appendix - Guidelines for Hospital Beds Re-Classification, LHIN Liaison Branch, Relations and Coordination Unit, MOHLTC

Guidelines for Hospital Beds Re-Classification

LHIN Liaison Branch
Relations and Coordination Unit
Ministry of Health and Long-Term Care

Hospital Beds Re-classification

From time to time a hospital may wish to reclassify beds (e.g. from rehabilitation to acute) for any number of different reasons. Any such reclassification must be approved by the Local Health Integration Network (LHIN) in the geographic area of the hospital. This type of approval is considered outside of the Hospital Annual Planning Submission (HAPS) Guidelines and the Hospital Service Accountability Agreement. For additional information see the HAPS 2008-2010.

If a hospital wishes to change the classification of beds, there are a number of issues the LHIN should consider before approving the application. Best practice suggests that the LHIN should require the hospital to submit a succinct business case detailing such information as:

- The rationale for the change in the classification, including an articulation that the re-classified beds will not be needed in the immediate future for the previous purpose. The hospital should present a compelling case for the reclassification, which may include such information as the changing demographics of its population or a need to alleviate pressures in other areas.

- Cost benefit analysis to determine financial implications addressing such issues as:

    - whether the reclassification will result in increased hospital costs;
    - whether the hospital will be able to manage within its allocation;
    - whether the hospital will need/request additional funds to offset the increased costs; and
    - whether there will be capital costs associated with the reclassification?

- Service availability and labour relations impact detailing such issues as:

    - whether there are sufficient health human resources to manage the reclassification; and
    - whether the reclassification will have an impact on labour relations or labour agreements?

- If the reclassification pertains to mental health beds, the *Mental Health Act* requires that the hospital be designated for that purpose and specific requirements must be met. Designation is made by the Minister of Health and Long-Term Care.

In some cases, the reclassification of beds may result in a change in the classification or grading of the hospital under the *Public Hospitals Act* Reg. 964. If this is the case, the hospital classification protocol referenced above must be followed to ensure the proper classification and/or grading.

In addition, bed classification will affect the Ministry's master numbering system. Inaccurate master numbers will have an adverse effect on hospital operations and undermine the utilization of appropriate data for funding, planning and management purposes.

To ensure that the Ministry's information is current, LHINs are asked to complete the attached form and submit it to the Ministry[1] for any bed reclassification request. Additional information concerning the process for notification of hospital classification and bed changes is attached as Appendix 1.

Ministry approval is not required for the reclassification of hospital beds.

Note:

The reclassification of hospital beds – as listed above - should not be confused with the classification of hospitals under the *Public Hospitals Act*. The two are completely different. The Ministry has developed a protocol setting out the process for the classification of hospitals. A copy of the protocol can be obtained from the Ministry of Health and Long-Term Care, LHIN Liaison Branch.

[1] The designation form should be submitted to: Standards and Data Management Unit, Health System Information Management Division, 5700 Yonge Street, 4th Floor, Toronto, ON M2M 4K5.

APPENDIX 1

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Ontario

Data Quality and Standards Unit
Health Data Branch
Health System Information Management Division

Unité de la qualité et des normes relatives aux données
Direction des données sur la santé
Division de la gestion de l'information sur le système de santé

5700 Yonge Street, 4th Floor
Toronto ON M2M 4K5

5700 rue Yonge, 4e étage
Toronto ON M2M 4K5

Telephone: (416) 327-7770
Facsimile: (416) 327-8951

Téléphone (416) 327-7770
Télécopieur (416) 327-8951

TO: LHIN CEO

FROM: Sue Turcotte
Manager, Data Quality & Standards Unit

RE: Process of Notification on Hospital Classification and Bed Changes

---

The purpose of this letter is to inform you of a process of notification on hospital classification and bed changes.

In the past our process included confirmation and verification of all changes by the respective ministry regional office before any changes were made within the IMU system (i.e., issue new facility #, Master Number, change to bed classification, etc.). The Standards & Data Management Unit of the Health System Information Management Division is responsible for the assignment and maintenance of the numbers and the publication of the Master Numbering System book. The master numbering data must be kept current on an ongoing basis for health services restructuring and implementation of clinical data reporting systems (e.g., complex continuing care, mental health, rehab, etc). **Inaccurate master numbers will have an adverse effect on hospital operations and undermine the utilization of appropriate data for funding, planning and management purposes.**

With the dissolution of the ministry regional offices, we are now referring such changes to the LHIN and requesting that you assign this to the most appropriate position within your LHIN organization. This individual will be responsible for confirming the changes by using the submission template (sample attached). The completed submission document should include copies of any supporting legal documentation, if necessary.

Upon receipt of the completed submission document, the Standards & Data Management Unit will carry out one of the following based on the type of change:

The Notification Process
Once the hospital designation has been approved, the following actions are required:

The LHIN will notify Dosta Sopkic, Statistical Officer (Dosta.Sopkic@moh.gov.on.ca) (Standards & Data Management Unit), immediately, by email using the submission template document (sample attached). The completed submission document should include copies of any supporting legal documentation, if necessary.

The Standards & Data Management Unit will carry out one of the following based on the type of the change:

A

New Unit	New Type Added	Assign New Unit
Type and Master Number; record number of beds and effective date	(e.g. AT, MH, CR, AM)	

B

Unit closure	Current units discontinued	Close Unit
Type from Master Number System, remove associated beds, and record effective and date.	(e.g. AT, MH, CR, AM)	

C

Bed number	Unit type	Bed Number Changed
change only	Unit type not affected	Record new bed number and effective start date

The Standards & Data Management Unit will communicate the new Activity/Unit Type, Master Number and bed number changes to the LHIN and other stakeholders. If applicable, expectation on new reporting requirements associated with the change will be included in the e-mail along with the effective date for data collection. For example, if a hospital receives new Schedule 1 Mental Health beds, the communication will indicate that OMHRS reporting is required with a starting date.

The LHIN will notify the appropriate hospital via e-mail or memo to confirm all changes and their corresponding effective dates.

Thank you for your ongoing cooperation and support in this process of managing timely and accurate information on hospital classification and bed changes.

Over the next few weeks we will be scheduling a short teleconference to review the process of notification on hospital classification and bed change.

Yours sincerely,

Sue Turcotte
Manager
Data Quality and Standards Unit
Health Data Branch

APPENDIX 2

Ontario

HOSPITAL DESIGNATION CHANGE NOTIFICATION

Instructions: Please complete the form below and email to Dosta Sopkic (dosta.sopkic@moh.gov.on.ca) for action. Questions can be directed to Dosta at 416.327.7777

Notice of change to the Standards & Data Management Unit: The following are changes to the hospital designation which will affect the Master Number system. Please make the appropriate changes and provide confirmation of the change and supporting information to (*insert name of LHIN submitting change notification*).

Section A: Purpose for Change in Hospital Profile Information

*Please select **ONE** only:*

1. ☐ Classification Change (type change)
2. ☐ Movement to Long Term Care (LTC)
3. ☐ Closure
4. ☐ Amalgamation (merger / split)
5. ☐ Name Change (the hospital should be asked to provide a copy of Supplementary letters patent)
6. ☐ New Unit
7. ☐ Other: specify:

Section B: Hospital Facility # and Name [(if already assigned) – delete this]

Facility Name:

Facility #:

Unit Type: Acute, Mental Health, Chronic, Rehab (Gen or Specific), Other:

Number of beds

Effective Date

Comments

Section C: Supporting Ministry or Legal Documentation

1. Document included
   (List all document submitted as part of this submission)

   _____

2. Supporting documentation forwarded (check one):

   ☐ Email: Dosta Sopkic (dosta.sopkic@moh.gov.on.ca)
   ☐ Fax: Dosta Sopkic (416-327-8951)
   ☐ Regular mail: Dosta Sopkic
   Standards and Data Management Unit
   Health System Information Management Division
   5700 Yonge Street, 4th Floor
   Toronto, Ontario M2M 4K5

Section D: LHIN Authorization

The names below acknowledge that the information above is accurate and complete to the best of our knowledge and represent the official sign off of those submitting this form.