Better client experiences.
Improved program planning and capacity.
Increased referral efficiency and collaboration.

These are only a few of the benefits achieved by the Toronto Central Local Health Integration Network since the launch of its Resource Matching and Referral Program in 2008.
From Problem to Solution

Ensuring the right care at the right place at the right time is top of mind when it comes to health care. On any given day, clients in acute or rehabilitation/complex continuing care settings are waiting to move to other, more appropriate health care settings. These clients account for 5% of hospitalizations, 14% of hospital days and almost 5,200 beds in health care facilities across Canada. In Ontario, clients waiting to be discharged to another care setting account for 7% of all hospitalizations. The Toronto Central Local Health Integration Network (TC LHIN) has used the Resource Matching and Referral Program to reduce these rates.

The TC LHIN developed the Resource Matching and Referral Program to facilitate transfers between acute and rehabilitation hospitals to in-home services, long-term care homes and community support services.

The goals of the program are to

- Understand system supply and demand;
- Improve access to care and appropriateness of care;
- Ensure optimal flow and process efficiency; and
- Enhance quality of care, client experience and equity.

Since its launch in 2008, the program has facilitated better client experiences by putting critical decision-support information related to referrals and wait times in the hands of clinicians, caregivers and senior decision-makers.

Current users include

- 6 acute hospitals
- 8 rehabilitation/complex continuing care hospitals
- 1 community care access centre
- 34 community support services agencies
- 37 long-term care homes

The Resource Matching and Referral Program facilitates matching of clients to appropriate programs or services based on their clinical needs.
In the summer of 2010, a survey was disseminated to all Ontario hospitals to be completed for clients who had been waiting to transition from acute care to another setting for longer than 40 days. An analysis of the survey results highlighted patterns and common characteristics typically associated with clients with more complex care needs.

To address these long wait times, one of the short-term strategies recommended by a special task force was to use the data from the program to support two processes:

- Identify and reach out to clients currently waiting longer than 40 days, allowing intensive case managers to develop an alternate transition plan to the right type of care.
- Proactively identify clients at risk of having long stays, based on patterns and common characteristics captured in referral data, and intervene earlier with an appropriate transition plan.

As a result, intensive case managers are now empowered with information to identify at-risk clients and help transfer them to the right place of care at the right time.

“We have received one of our first reports and we are excited to have information to support the proactive identification and transition of clients into appropriate care settings. With this information we can continue to further develop and refine the criteria for early identification and enhance the overall experience for our clients.”

—Dionne Williams, Manager, Client Services, Toronto Central Community Care Access Centre
How It Works

The program is enabled by a shared electronic referral management and resource matching tool.

Service providers in various health care settings, such as acute care hospitals and community support agencies, enter point-of-care data into common, standardized electronic referral forms.

Mandatory fields on the electronic forms capture clients’ demographic, care-planning and medical assessment information.

In some settings, such as long-term care homes, staff indicate which beds are not occupied and available to be matched to clients.

The tool uses this data and the built-in matching functionality to indicate the most appropriate programs or services, based on client need and service availability, and allows providers to better counsel clients and families.

The data entered in this tool acts as a single source of referral information that can be used region-wide to support decision-making both at and beyond the point of care.

Standardized criteria are used to match clients with appropriate post–acute care facilities. If a facility does not accept a client, a reason for denial must be provided. Decision-makers review data trends to understand where health system gaps exist and to initiate action.

The program is sponsored by the TC LHIN and is delivered in partnership with the University Health Network. Initial funding was provided by the Ministry of Health and Long-Term Care. Subsequent expansion has been funded by the TC LHIN, with operational funding provided by participating acute, rehabilitation and complex continuing care health service provider organizations and the Toronto Central Community Care Access Centre.
Who Benefits, and How

Clients

Client transfers to care settings happen more efficiently, equitably and transparently. The result—clients are now transferred to care settings that meet their needs and provide an improved client experience.

Providers and Other Caregivers

Through the tool, providers can easily access a comprehensive list of suitable programs and services that match client needs. This allows them to better counsel clients.

Senior Decision-Makers

Senior decision-makers, including chief executive officers within the TC LHIN, use system-level reports to inform quality improvements and resource allocation decisions at quarterly meetings. They also use system-level reports to better understand utilization trends, bottlenecks and service gaps to set performance targets and inform policy.

Similarly, senior decision-makers use monthly provider-level reports to monitor client transitions in care and referral patterns.

Provider-level reports
provide site–level referral information for acute, rehabilitation and complex continuing care, home care, long-term care and community support services organizations.

System-level reports
are produced monthly and aggregate information from all participating sites.
The data showed that clients with high wound care needs who had unique care requirements, such as for special mattresses, had long wait times. As a result, the TC LHIN is now exploring the creation of a centre of excellence for wound care, one of several possible responses to providing the most appropriate care.

Before the availability of centralized referral data, decision-makers were unable to properly analyze why the specific needs of clients were not being met when waiting for a transfer to another facility. Equipped with this newly available information, they were better able to recognize the challenges facing specific clients and take action to improve access to appropriate care.

“Our referral data helped us better understand the needs of our clients and make changes to our care process. This information helped us make the program work more effectively and efficiently for the clients. The information we collect through the Resource Matching and Referral Program will continue to make a meaningful contribution to a comprehensive, comparable picture of client transitions across sectors.”

—Rachel Solomon, Senior Director, Performance Measurement and Information Management, Toronto Central Local Health Integration Network
Same-day referrals are referrals to home care that are initiated the same day a client is discharged from acute, rehabilitation or complex continuing care hospitals. For some clients, this quick transition back home can bring a sense of anxiety. They may not be familiar with the service plan they will receive, or they may not have made arrangements for care. For the health system, there are pressures to ensure that adequate resources are in place to facilitate discharge and to support successful reintegration into the community.

Based on the data captured through the program, senior decision-makers are better able to understand the occurrences of same-day referrals. To better plan for discharges, they have implemented collaborative strategies, such as having a home care coordinator attend client rounds along with other care team members to identify clients who may be ready to be discharged. Since implementing these strategies, same-day referrals to the community care access centre’s in-home services have decreased—from 40% in April 2010 to 29% in March 2011.

“Access to great data provides evidence of how the health care system is performing and allows us to track our progress as the Toronto Central Local Health Integration Network moves toward implementing the best practices for our clients. Comprehensive data is essential to system change and innovation because if you track and measure, you can improve client care. I’m proud of the meaningful information to date and am excited about the progress we continue to make that will improve the quality of and access to care for clients.”

—Camille Orridge, CEO, Toronto Central Local Health Integration Network
The Way Forward

More data will become available as the program is implemented at additional sites and broadened to include more referral pathways, such as mental health and addiction services.

The TC LHIN is actively working to develop a robust and sustainable Resource Matching and Referral Reporting and Analytics Program to continue to provide meaningful information to support business or process change and allow for better decision-making at all levels. This program can also serve as a model for other provinces to help clients get the right kind of care when they need it.

The appropriate use of high-quality information on health needs, services and outcomes is critical to the future of Canada’s health system. Clinicians need information to support their care planning decisions. Health system managers need information for planning, quality monitoring and accountability. Policy-makers and senior decision-makers need information for system management and accountability. This product is one in a series designed to showcase the use and value of information at these various levels.

Acknowledgements

The Canadian Institute for Health Information (CIHI) would like to acknowledge and express appreciation to the individuals and organizations whose stories have been showcased as part of this project.

Special thanks go to the Shared Information Management Services (SIMS) Partnership of the University Health Network for its guidance in developing the content included here.