Inpatient and Outpatient Stroke Rehab Referral and Transition Standards 2024

January 2024

Toronto Stroke Networks

Stroke Rehab Referral Overview

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Care Settings	**Acute Care** (incl. SPC/TAMS)	**Inpatient Rehab**	**Community**
Referral Type	**Inpatient and Outpatient Referrals**	**Outpatient Referrals**	**Outpatient Referrals**
Standards	Follow slide 4 • 2 referrals to inpatient program closest to home **OR** • 1 referral to outpatient program closest to home	Follow slide 5: • 1 referral to outpatient program closest to home	Follow slide 5: • 1 referral to outpatient program closest to home
Referral Approach	Use eStroke Rehab Referral System	• Use eStroke Rehab Referral System for referrals to an external OP program • Use organization processes for internal OP referrals	Use rehab referral form (available at http://www.gtarehabnetwork.ca/referral-forms-new) Send to outpatient program

Acute Care team decision to refer to Inpatient Rehab:

- Patient has rehab goals and demonstrates ability to participate and learn
- Patient meets all criteria on medical stability list (Appendix 1b)
- Considers rehab organization's ability to accept patients with specific care needs (Appendix 2)

eStroke Rehab Referral and Transition Process Map

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AlphaFIM® Score >80

Acute and Rehab:
Follow eStroke outpatient referral standards (slide 4)

Rehab:
- **1 business day response timeline**
- Automatic acceptance to program *
- Provide admission date within 7 days of discharge from acute care

Acute:
- Use Outpatient Rehab Transition Letter to provide start date and contact information before patient is discharged

Acute:
- Provide follow up phone call to patient with start of therapy date if patient was discharged before OP intake response was received.

Admit to OP Rehab

AlphaFIM® Score >80
(with challenges/concerns preventing safe discharge home)

Acute and Rehab: Use process map for **AlphaFIM® Score** 40-80 based on time post stroke

Challenges/concerns preventing safe discharge may include:
- Cognitive/perceptual needs
- Severe memory impairment
- Severe aphasia/dysphagia
- Profound inattention/neglect
- Nursing needs/social support

AlphaFIM® Score 40-80

Acute and Rehab: Follow eStroke inpatient referral standards (slide 4)

Rehab:
- **2 hour response timeline**
- Automatic acceptance and bed offer * ∞
- Provide admission date

Acute:
- Discussion with patient and family
- Inform rehab which facility patient has accepted. Cancel other offers

AlphaFIM® Score < 40

Rehab:
- **2 hour response timeline**
- Review of referral by rehab
- Provide intake decision:
  - ❑ Anticipated date of admission
  - ❑ Pending: request for more information
  - ❑ Decline (with reason)

Acute:
- Respond to rehab as appropriate based on rehab responses
- Inform rehab which facility patient has accepted. Cancel other offers

Provide an Essential Professional Conversation (see slide 14) to support the transition of care as required or where complex needs exist (Patient Complexity Framework slides 12, 13)

Acute:
- Use of Discharge Check List to send appropriate information at time of transfer to rehab
- Use of Inpatient Rehab Transition Letter

Admit to HIGH INTENSITY Rehab

Admit to HIGH INTENSITY or LOW INTENSITY Rehab

*Assumes patient meets admission criteria for rehab program.

∞ Patients with special needs may require follow up

Supporting documents can be found at https://resourcematchingandreferral.com/best-practices/estroke-pathway/

eStroke Rehab Referral and Transition Standards (acute care to inpatient and outpatient rehab)

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Acute to Outpatient (OP) Referrals AlphaFIM® Score >80

Acute:

- Refer to **1** OP site
- Contact patient if OP start date information is received after the patient has been discharged e.g. weekend discharge.

Prior to discharge:

- Provide patient with *OP Transition Letter*, include first treatment date and contact information
- Work with patient/caregiver to ensure plan for transportation

OP Rehab:

- OP referrals are automatically accepted*
- Provide electronic intake response with start date, target **1 business day**
- Contact patient following acute discharge to confirm start date/time

NOTE:

- Target start of treatment is within 7 days of discharge from acute.
- First treatment date includes initial assessment and start of therapy.

*assumes patient meets admission criteria for OP rehab program

Acute to Inpatient (IP) Referral AlphaFIM® Score 40-80 Acute

Acute:

- Refer to **2** rehab sites closest to home/discharge destination (supports transition to OP)
- Refer to 2 more sites if patient is not transitioning to rehab within 2 days.
- Ensure referrals show consistent information across the disciplines.
- Accept the appropriate bed offer and decline others on receipt of offers.
- Provide patient with *Inpatient Transition Letter*
- Send information outlined in *Inpatient Discharge Check List* with patient on transfer to rehab

IP Rehab:

- Referrals with an **AlphaFIM® Score 40-80** (within 7 days post stroke) are automatically accepted*
- Patients with special needs may require follow up
- Provide electronic intake response to referrals within:
  - **2 hours** with an admission date (for referrals sent on business days before 3pm)
  - 1 business day – referrals sent after 3pm

Acute to Inpatient Referral AlphaFIM® Score < 40

Acute:

- Refer to **3** rehab sites closest to home/discharge destination (supports transition to OP).
- Ensure referrals show consistent information across the disciplines
- Provide patient with *Inpatient Transition Letter*
- Send information outlined in *Inpatient Discharge Check List* with patient on transfer to rehab

IP Rehab:

- Provide electronic intake response to referrals within:
  - **2 hours** with an admission date (for referrals sent on business days before 3pm)
  - 1 business day – referrals sent after 3pm

Admit patients into eStroke System: Admit patient in vacancy module upon arrival, to ensure wait time accuracy

Acute, IP and OP Rehab: Consideration should be given to provide an Essential Professional Conversation (EPC) or "warm handover" (see slide 14) to support the transition experience for patients with complex needs (see Patient Complexity Framework slides 12 and 13).

Supporting documents can be found at https://resourcematchingandreferral.com/best-practices/estroke-pathway/

eStroke Rehab Referral and Transition Standards (inpatient/ community to outpatient rehab)

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Inpatient (IP) to External Outpatient (OP) Referral

IP Rehab:

- OP rehab goals identified
- Discuss with patient/family OP sites. Consider distance, transportation, wait times, etc
- Refer to **1** OP rehab site
- Confirm OP contact information upon discharge
- Submit referral minimum of 48 hours prior to discharge

Prior to discharge

- Provide patient with *OP Transition Letter* include first treatment date and contact information
- Work with patient/caregiver to ensure plan for transportation

OP Rehab:

- Provide electronic response within **1 business day**. Include:
  - Program contact information
  - OP start date of first treatment, or approximate wait time
- Target start date is within 7 days of discharge or as appropriate to patient need.

Admit patient into eStroke System:

- Admit patient in vacancy module upon arrival for their first treatment to ensure wait time accuracy
- First treatment date includes initial assessment and start of therapy

Community to Outpatient (OP Referrals)

Community:

- OP rehab goals identified
- Family physician/ health team to discuss with patient OP options (geography/transportation considered)
- Fill out referral form (available at http://www.gtarehabnetwork.ca/referral-forms-new)
- Send referrals to OP Program

OP Rehab:

- Arrange OP initial assessment directly with the patient
- OP Initial assessment will confirm complement of therapies and services required

Prioritization of OP referrals:

1. Referrals from acute, inpatient rehab (internal and external referrals)
2. Community referrals with no prior rehab within 4 months of the stroke onset date, receive same priority admission as referrals from acute care and inpatient rehab.

Acute, IP and OP Rehab: Consideration should be given to provide an Essential Professional Conversation (EPC) or "warm handover" (see slide 14) to support the transition experience for patients with complex needs (see Patient Complexity Framework slides 12 and 13).

Supporting documents can be found at https://resourcematchingandreferral.com/best-practices/estroke-pathway/

Automatic Acceptance of stroke patients with AlphaFIM® 40-80 (≤ 7 days post stroke)

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Acute

- Ensure team considers the following when submitting referrals
  - Patients have clearly identified rehab goals
  - Meets eligibility and medical stability criteria (Appendix 1a and 1b)
  - Rehab organization's ability to accommodate the specific care needs of the patient (Appendix 2)
- Refer to no more than 2 rehab sites closest to patient's home postal code or anticipated home discharge destination
- If the rehab organizations are unable to admit within 2 days, apply to an additional 2 sites
- Initiate EPCs for patients with complex needs to support transition

Rehab

- Response to referral within 2 hours of referrals sent on business days (note: next business day if referral sent after 3 pm)
- Stroke patients with AlphaFIM® 40 – 80 ≤ 7days post stroke, referrals should be automatically accepted and admission to inpatient rehab within 2 days
- Some patients may require additional planning considerations that would result in bed offer of ≥ 2 days (Appendix 3)
- Engage in EPCs with acute to support patient transition
  - Identify patients who would have benefited from EPCs to inform quality improvement

Appendix 1a: Eligibility Criteria for Bedded Rehabilitative Care

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A patient meets all of the below criteria to be eligible for rehab. The patient:

1) Has restorative potential*, i.e. the patient's/client's condition is likely to undergo functional improvement and benefit from rehabilitative care

2) Is medically stable such that s/he can be safely managed with the resources that are available within the level of rehabilitative care being considered (see Appendix 1b)

3) Has identified goals that are specific, measurable, realistic and timely; and

4) Is able to participate in and benefit from rehabilitative care (i.e., carry-over for learning) within the context of his/her specific functional goals

5) Has goals/care needs that cannot otherwise be met in the community.

*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.

Adapted from Rehab Care Alliance: Definitions Framework for Bedded Levels of Rehabilitative Care 2017

Appendix 1b: Medical Stability Criteria

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A patient meets all 5 criteria to be considered medically stable:

- ❑ A clear diagnosis and co-morbidities* have been established
- ❑ At the time of discharge from acute care, acute medical issues have been addressed; disease processes and/or impairments are not precluding participation in the rehab program
- ❑ Patient's vital signs are stable
- ❑ No undetermined medical issues* (e.g. excessive shortness of breath, falls, congestive heart failure
- ❑ Medication needs have been determined

*All medical investigations have been completed or a follow-up plan is in place at time of referral and follow-up appointments made by time of discharge.

Adapted from GTA Rehab Network: Inpatient Rehab/LTLD Referral Guidelines 2009

Appendix 2: Rehab organization's ability to accommodate specific care needs of the patient

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Patient is medically stable as per the medical stability criteria but has one or more of the following:

X Not able to accommodate ✓ Able to accommodate **EPC** – Essential Professional Conversation

	Bridgepoint	Providence	St John's	Toronto Rehab	West Park
NG Tube	X	X	X	X	X
Hemodialysis (HD)	✓On-site HD	✓ Off-site HD* ✓ EPC required	✓ Off-site HD* ✓ EPC required	X	✓ Off-site HD* ✓ EPC required
Peritoneal Dialysis (PD)	✓	✓	X	X	X
Locked Unit	X	X	X	X	X
IV Chemotherapy	✓ EPC required	X	X	X	X
Enteral Feeds**	✓	✓	✓	✓	✓

*Patient must be able to attend off-site HD appointments safely and independently or with family and/or caregiver support, after 3 pm
**Patients on either intermittent or continuous enteral feed schedules should be off feeds for a minimum of 4 hours between 8 am - 4 pm. The 4 hours off feeds can be broken up. *(If the above schedule is not achieved, transfer to rehabilitation should not be delayed. Rehabilitation facilities should accept the patient and establish the schedule as soon as possible.)*

Appendix 3: Additional Considerations to Support Transfer to Rehab

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An essential professional conversation may be required for the following:

- Supplemental oxygen:
  - Note: home oxygen may need to be arranged
- IP&C: precautions/isolation needs
- Specialized equipment: i.e. bariatric, VAC, air mattress
  - New hip width field in development in eStroke System
- Tracheostomy
- Pre-existing/emerging conditions that require a plan of care to support patient's transition to rehab (e.g. behavioral or psychiatric conditions)

Program Contact Information

Toronto Stroke Networks

Inpatient Rehab Facility

	Contact Phone	Fax Number
Bridgepoint Health	416-461-8252 x 2298	416-461-5499
Providence Healthcare	416-285-3666 x 4382	416-285-3759
St John's Rehab	416-226-6780 x 7158	416-226-4431
Toronto Rehab	416-597-3422 x 3618	416-597-7141
West Park Healthcare	416-243-3600 x 2135	416 243 8397

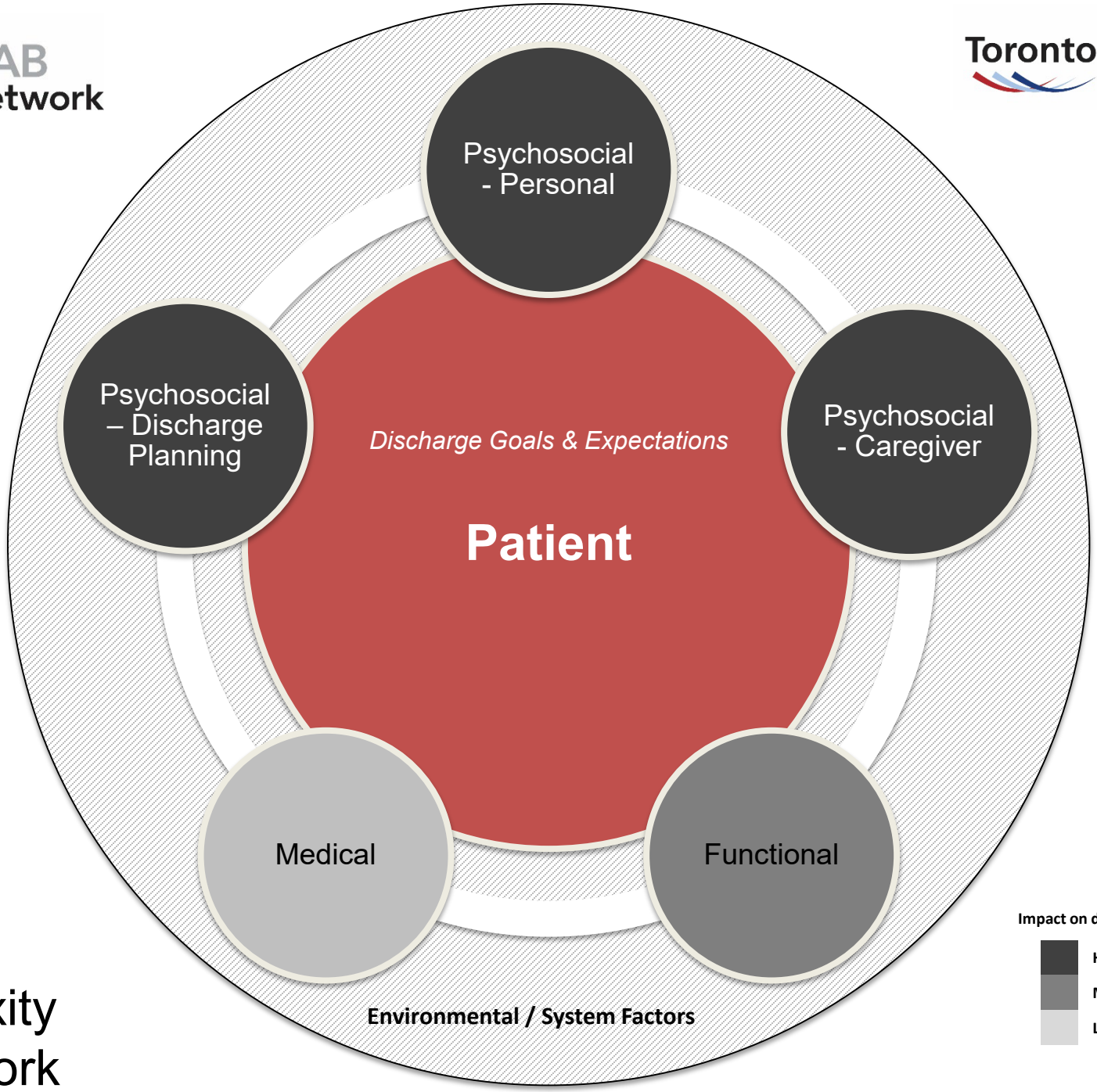
Outpatient Rehab Facility

	Contact Phone	Fax Number
Bridgepoint Health	416-461-8252 x 2278	416-461-2089
Providence Healthcare	416-285-3666 x 4382	416-285-3759
St John's Rehab	416-226-6780 x 7165	416-226-3358
Toronto Rehab	416-597-3422 x 3221	416-597-7141
West Park Healthcare	416-243-3600 x 2420	416-243-1863

Patient Complexity Framework[1]

PSYCHOSOCIAL - PERSONAL	PSYCHOSOCIAL – DISCHARGE PLANNING	PSYCHOSOCIAL - CAREGIVER	FUNCTIONAL	MEDICAL
Personal characteristics (coping mechanism, high stress/anxiety levels, mood, motivation, etc.)	Challenging home situation: physical (homelessness, inadequate/poor housing)	Lack/limited social supports	Mobility/ALD/IADL needs that cannot be met by current support systems (e.g., falls, weight-bearing status, incontinence)	Specialty medical equipment needs (e.g., bariatric support, ventilator, hemodialysis, CPAP)
Social history (addiction, mental health issues, hoarding, legal/criminal)	Environmental barriers of discharge destination (e.g., infection control requirements, physical environment)	Caregiver burden and family relationships/ dynamics	Behavioural issues requiring specific management strategies (e.g., need for a sitter, locked unit or psychiatry support)	Multiple complex medical care needs requiring treatment at a high frequency and set multiple timeframes (e.g., tube feeds, suctioning, turning, cancer treatment)
Risk to self or others	Lack of discharge destination		Cognitive impairment / delirium / dementia	≥ Stage 2 pressure ulcer(s) and complex wound care needs
High intensity social service utilization	Socioeconomic status (e.g., no OHIP coverage, available financial resource)		Communication issues due to - Aphasia - English as a second language barrier - Hearing impairment	Complex medical regimes and/or polypharmacy
Role of patient (e.g., as caregiver)			Pre-existing conditions affecting function (e.g., visual impairment)	

1. Based on the Integrated funding model – Stroke project 2016-2017, the GTA Rehab Network Transitions 2013 Initiative, and referral triggers - TC LHIN ALC transition team 2012, Think Tank: Understanding complexity of patients post-hip fracture and stroke 2017.



Patient Complexity Framework

Essential Professional Conversations (EPCs) or "Warm Handovers"

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- Goal of EPCs (or "warm handovers") is to enable and enhance conversations between healthcare providers from different sectors of the care continuum at times of transition. This ensures the most seamless, optimistic care for persons with stroke.

- For more information about EPCs, go to: http://www.tostroke.com/for-professionals/research-and-quality-improvement/.

- Contact information to support EPCs will be housed on the Toronto Stroke Networks' Virtual Community of Practice (VCoP). For instructions on how to access or update this information on the VCoP, go to the above website link.

- If your facility/organization is not represented in the contact lists, please add your team's contact information to the EPC Contact Lists and Team Descriptions Template. Send your completed template to info@tostroke.com. A copy of this template can be found in the above website link.