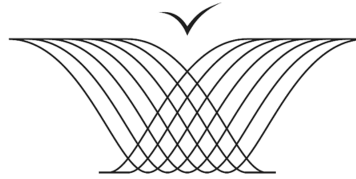

Development of Inpatient Rehab Referral Guidelines

GTA Rehab Network ALC Subgroup
Final Report, July 2005

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1.0 INTRODUCTION

1.1 Background

In early 2003, the GTA Rehab Network identified the need to quantify and better identify the types of patients waiting for rehabilitation, the services for which they were waiting and the reasons for waiting. Between April and September 2003, the GTA Rehab Network's ALC (Alternate Level of Care) Task Group conducted a series of five snapshots to capture detailed information about patients awaiting rehab in ALC in organizations across the GTA. The findings of these surveys and attendant recommendations are summarized in the GTA Rehab Network report, *Analysis of Alternate Level of Care (ALC) Snapshots: Patients Awaiting Rehabilitation in ALC and Inpatient Rehabilitation Capacity (May 2004).*

In the spring of 2004, a new ALC Task Group was struck to oversee the implementation of the recommendations outlined in the Network's ALC report. The ALC Task Group advised that a smaller subgroup be struck to address one of the report's recommendations: to develop a set of guidelines for the rehabilitation referral process for use by both acute care and rehabilitation hospitals. The guidelines would improve communication between referring and receiving facilities and optimize the transfer of patients from one level of care to the next. The development of these guidelines would be done in collaboration with the Referral and Response Form Task Group of the GTA Rehab Network to ensure that the guidelines support and complement the use of its standardized referral and response form for MSK patients.

1.2 GTA Rehab Network ALC Subgroup

In the fall of 2004, the GTA Rehab Network's ALC Subgroup was convened. As with all Network committees, subgroup members were selected based on broad representation of Network members who had the skills and experience appropriate to the tasks of the committee. Representation included members from the six regional rehab centres, each of the acute teaching hospitals and the west and east GTA (see Appendix 1). There was also cross-representation with the Referral and Response Form Task Group. Meetings were held on a monthly basis over a period of seven months.

1.3 Scope of Project

The mandate of the ALC Subgroup was to develop a set of common guidelines for the rehab referral process that would be used by acute care and rehab facilities. The objectives of the ***Inpatient Rehab Referral Guidelines*** were to promote best practices in the rehab referral process, to increase consistency in the application of definitions and to foster a more streamlined and consistent referral process. Specifically, the guidelines would achieve its objectives by addressing:

- the timing of referrals relative to ALC designation and rehab readiness
- responses to referrals
- number of referrals to be submitted by referring organizations.
- definitions of medical stability, rehab readiness and Alternate Level of Care (ALC) designation

Following the development of these guidelines, the ALC Subgroup would submit the draft guidelines to the larger ALC Task Group for final approval and dissemination. Once the guidelines were disseminated and in use, the expected outcomes of the guidelines would be:

- Improvements in patient flow
- Increased clarity and consistency in the rehab referral process
- Improved communication between referring and rehab facilities.
- Increased consistency in use of the definitions of rehab readiness, medical stability and ALC

2.0 APPROACH

2.1 Development of Definitions

The first step of the ALC Subgroup was to develop definitions for rehab readiness, medical stability and ALC. Historically, these terms have been understood and used differently by acute care and rehab. To address this, subgroup members reviewed the policies and definitions in use at each organization to develop definitions that would reconcile the discrepancies that existed between the application of these definitions in acute care and rehab. In addition, a brief questionnaire guideline was developed to obtain feedback from the clinical teams in each type of facility (see Appendix 2). Subgroup members also reviewed Trillium Health Centre's *Rehab Readiness Tool and Admission Criteria* to assist with the development of the definitions.

2.2 Development of Guidelines

Once feedback was obtained and reviewed, the subgroup set about developing an initial draft of the ***Inpatient Rehab Referral Guidelines***. The subgroup agreed on the following principles:

- The guidelines would be applicable to inpatient rehab only.
- The guidelines would be written so that they would be applicable to all levels of inpatient rehabilitation (i.e., regular and low tolerance long duration) and all rehab population groups.
- The guidelines were to be applied in conjunction with the specified admission criteria of individual inpatient rehabilitation programs.
- The guidelines would be organized around patient-specific criteria (e.g. suitability to participate in a rehab program based on the patient's rehab goals, medical stability and readiness for rehab) rather than system-specific criteria (e.g. resources available at rehab facilities).
- The guidelines would strive to narrow the gap between the determination of a patient as rehab ready and ALC.
- The guidelines would incorporate the response categories developed by the Network's Referral and Response Task Group in the *Guideline for Responses to Referrals*.

Informal feedback from the clinical teams at each organization on various draft versions of the guidelines was solicited on several occasions.

2.3 Evaluation of the Inpatient Rehab Referral Guidelines:

ALC Subgroup members agreed that it fell within the mandate of the ALC Subgroup to conduct a formal process evaluation of the ***Inpatient Rehab Referral Guidelines*** to determine if the content of the guidelines was relevant, appropriate and useful to the rehab referral process for those in acute care who refer to rehab programs and those in rehab who review the rehab applications. A survey questionnaire was developed (see Appendix 3). Subgroup members were asked to circulate the draft guidelines along with the survey to up to five individuals/teams involved in the rehab referral process at each organization represented by subgroup members.

Survey respondents were asked to rate:

- each component of the draft ***Inpatient Rehab Referral Guidelines*** on its usefulness/effectiveness with respect to the rehab referral process
- the comprehensiveness of the draft ***Inpatient Rehab Referral Guidelines*** in addressing all key elements of the rehab referral process
- the overall clarity of the draft ***Inpatient Rehab Referral Guidelines***.

Survey respondents were also asked to indicate:

- whether the draft ***Inpatient Rehab Referral Guidelines*** are applicable to all rehab population groups
- which types of rehab population groups are admitted to their clinical settings in which they work

2.4 Evaluation Results[1]

Thirty-three surveys were received with fairly equal representation from both acute care (42%) and rehab (54.5%). Survey results were very positive: 80% of averaged acute care responses to questions received a rating of 4 or higher[2]; and 90% of averaged rehab responses to the questions received a rating of 4 or higher. In general, there were no significant differences in average scores provided by acute care and rehab. Results also indicated that each rehab population group as defined by the OHA categorizations[3] was represented in the clinical settings surveyed. This result adds weight to the finding that 94% or more of respondents indicated that the draft ***Inpatient Rehab Referral Guidelines*** were applicable for all rehab populations.

The ALC Subgroup reviewed the survey results in detail and a final draft of the ***Inpatient Rehab Referral Guidelines*** was prepared based on the feedback received (see Appendix 5). Specifically, changes were made to the introduction to clarify the objectives of the guidelines and highlight that the guidelines are to be applied in their entirety and in conjunction with admission criteria of individual inpatient rehabilitation programs. This change was made because some of the survey results indicated that the respondents had not read each section of the guidelines as carefully as required. Further, the survey results indicated that a few respondents found the information regarding ALC coding confusing. Since the information about ALC coding is a product of the Canadian Institute for Health Information and therefore outside the

[1] For details of evaluation results, see Appendix 4.
[2] A 5-point Likert rating scale was used: 1 = Not effective/reasonable/useful; 5 = Very effective/reasonable/useful
[3] OHA Rehabilitation Working Group, Rehabilitation Program Definitions March 1999

purview of the GTA Rehab Network, a decision was made to condense the information about ALC in the appendix section to a brief descriptive section.

3.0 RECOMMENDATIONS TO ALC TASK GROUP

The ALC Subgroup submitted the following recommendations to the ALC Task Group:

i) Based on the input that has been received from each organization throughout the development of the ***Inpatient Rehab Referral Guidelines*** and the positive results of the evaluation survey, the ALC Subgroup recommends that the ALC Task Group accept the final draft of the ***Inpatient Rehab Referral Guidelines*** as written.

ii) The ALC Subgroup recommends that an outcome evaluation of the guidelines be conducted once the guidelines have been in circulation for a period of time. Subgroup members note that it might be difficult to pinpoint any changes in the rehab referral process specific to the implementation of the guidelines as many organizations have implemented other measures to reduce ALC days since the Network's ALC Snapshots were conducted in the spring/summer of 2003. The establishment of a baseline would therefore be of benefit. One possible strategy to achieve this may be to use the snapshots conducted by the Central Emergency Network as a baseline regarding ALC data before distribution and implementation of the ***Inpatient Rehab Referral Guidelines***.

iii) The ALC Subgroup also recommends that the ALC Task Group develop a marketing strategy to increase awareness and utilization of the ***Inpatient Rehab Referral Guidelines*** in each member organization.

iv) The ALC Subgroup requests that its members be informed (via email) regarding the ALC Task Group's decision regarding the acceptance, distribution and evaluation of the guidelines.

4.0 ADDENDUM

Following completion of its mandate, the ALC Subgroup was disbanded in May 2005. The ALC Task Group approved the ***Inpatient Rehab Referral Guidelines*** and a dissemination plan for Fall 2005 in acute care hospitals, freestanding rehab facilities and in acute care hospitals with inpatient rehab units/programs or designated rehab beds.

5.0 APPENDICES

5.1 Appendix 1
Members of ALC Subgroup

Donna Barker, St. John's Rehab Hospital *(Chair)*
Shawn Brady, Providence Healthcare
Donna Cheung, Toronto Rehab
Debbie Galet, St. Michael's Hospital
Dana Katz, Mt. Sinai Hospital
Helen Levin, University Health Network
Carmelina Peluso, Rouge Valley Health System
Fatima Sheriff, University Health Network
Kim Sterling, Bridgepoint Health
Gilda Theriault, William Osler Health Centre
Jane Turner, West Park Healthcare Centre

Charissa Levy/Heather Brien, GTA Rehab Network
Sue Balogh, GTA Rehab Network

5.2 Appendix 2
ALC Subgroup Questionnaire Guideline For Acute Care & Rehab Teams

The following is a series of questions to help guide the discussion with your clinical team regarding the decisions involved in **referring/accepting** a patient for inpatient rehab. Please feel free to expand your discussion to include other questions or comments as you see fit. If possible, please consult with other teams in your organization.

Type of Clinical Team/Program(s) Consulted: ___________ Date: __________________

1. In general, what factors or patient characteristics do teams use to determine if a patient is a candidate for rehab?

2. How do teams decide when to submit a rehab application? (e.g. written medical order by attending physician; team consultation/assessment)

3. What are the key factors to determine if a patient is "rehab ready"?

4. When are referrals made relative to "rehab readiness"?

5. What are the criteria used to determine if a patient is ready for ALC designation? (For acute care only).

6. Does your team/organization have guidelines for when to submit a rehab referral relative to ALC designation? If so, please specify. (Acute care only)

7. From your program/organization's perspective, what are the key criteria used to determine if a patient is medically stable and ready for discharge/admission to rehab?

8. Who participated in this interview?

□ Case Manager	□ SLP	□ OT
□ PT	□ SW	□ RN
□ Nurse Practitioner	□ Physician	□ Resident

5.3 Appendix 3 Inpatient Rehab Referral Guidelines Survey

Background:

The ALC Subgroup was convened to address the recommendation in the GTA Rehab Network's ALC report[4] to develop a set of guidelines for the rehabilitation referral process. The rehab referral guidelines will be used by both acute care and rehabilitation hospitals to improve communication between referring and receiving facilities and optimize the transfer of patients from one level of care to the next.

We are conducting a **process evaluation** of the Rehab Referral Guidelines (attached) to evaluate if the content of the Rehab Referral Guidelines is appropriate, relevant and useful to those in acute care who refer to rehab programs and those in rehab who review the rehab applications. An **outcome evaluation** to determine if these guidelines improve the rehab referral process will be conducted in future following the circulation and use of the guidelines by GTA Rehab Network members.

Please complete the following brief survey. Your feedback is greatly valued.

1. Please indicate which type of clinical setting you work in:
□ Acute care □ Rehab Organization: ______________________________________

2. Please indicate the clinical population on your unit. Check all that apply.
□ ABI □ Amputee □ Burns □ Cardiac □ Chronic Pain □ Geriatric □ MSK
□ Neurology □ Oncology □ Respiratory □ Spinal Cord □ Stroke □ Trauma □ Other

3. Who is completing this survey?
□ Discharge Planner/Case Manager □ Allied Health (please specify): __________________
□ Admissions/Service Coordinator □ Other (please specify): ________________________

4. Please rate the effectiveness of the Guidelines in providing information that will **help you to assess** if the patient is:

suitable for rehab……………………	*Not Effective*	1	2	3	4	5	*Very Effective*
medically stable for transfer to rehab…	*Not Effective*	1	2	3	4	5	*Very Effective*
ready for rehab………………………..	*Not Effective*	1	2	3	4	5	*Very Effective*

Comments:
____

5. Please rate the effectiveness of the Guidelines in providing information about **when to submit a rehab application.**

Not Effective 1 2 3 4 5 *Very Effective*

Comments:
____

6. Please rate the effectiveness of having **referral response categories** listed in the Guidelines. (See Guideline for Timing of Responses to Referrals)

Not Effective 1 2 3 4 5 *Very Effective*

Comments:
____

[4] *Analysis of Alternate Level of Care (ALC) Snapshots: Patients Awaiting Rehabilitation in ALC and Inpatient Rehabilitation Capacity.* GTA Rehab Network, May 2004.

7. Please rate the extent to which you think it is reasonable to recommend that **responses to referrals** should occur within 2 business days of receipt of application.

Not Reasonable 1 2 3 4 5 *Very Reasonable*

Comments:

____

____

8. Please rate the extent to which you think it is reasonable to recommend that **organizations refer to 2-3 organizations?**

Not Reasonable 1 2 3 4 5 *Very Reasonable*

Comments:

____

____

9. Please rate how useful it is to have information about ***Rehab Finder*** in the Guidelines.

Not Useful 1 2 3 4 5 *Very Useful*

Comments:

____

____

10. Please rate how useful it is to have information about the **ALC codes** in the Guidelines.

Not Useful 1 2 3 4 5 *Very Useful*

Comments:

____

____

11. Do you think that the Guidelines can be **applied to all rehab populations**? □ Yes □ No

If no, please specify:

Comments:

____

____

12. Do the Guidelines address the **key elements** involved in the rehab referral process?

□ Yes □ No

If no, please specify:

Comments:

____

____

13. Please rate the **overall clarity** of the Guidelines.

Not Clear 1 2 3 4 5 *Very Clear*

Other Comments:

____

____

Thank you for taking the time to complete this survey.

Please return your survey by April 15, 2005 to the GTA Rehab Network:

Fax : 416-597-7021 <u>or</u> Email: info@gtarehabnetwork.ca

5.4 Appendix 4
EVALUATION RESULTS

Evaluation Objective: To evaluate the content of the ***Inpatient Rehab Referral Guidelines*** for appropriateness, relevance, and usefulness to the rehab referral process for those in acute care who refer to rehab programs and those in rehab who review rehab applications.

EVALUATION RESULTS*						
Acute Care: N = 15 Rehab: N = 18 Total N = 33	**Acute Care Average**	**Rehab Average**	**Acute Care Median**	**Rehab Median**	**Acute Care Mode**	**Rehab Mode**
Question 4a: Suitable for rehab	4.0	4.4	4	4.5	4	5
Question 4b: Medically Stable	4.2	4.6	4	5	4	5
Question 4c: Ready for Rehab	4.1	4.5	4	5	4	5
Question 5: When to Submit Application	3.5	4.3	3	4	3	4
Question 6: Response Categories	4.2	4.5	4	5	4	5
Question 7: Timeline for Responses	4.7	4.2	5	4	5	5
Question 8: No. of Referrals	4.5	4.2	5	4	5	5
Question 9: Inclusion of Rehab Finder	4.3	4.3	4	4	4	4
Question 10: Inclusion of ALC Codes	3.7	3.8	4	4	3	5
Question 11: Applicability	Yes = 93% (14/15)	Yes = 94% (17/18)	N/A	N/A	Yes	Yes
Question 12: Key Elements Represented	Yes = 93% (14/15)	Yes = 94% (17/18)	N/A	N/A	Yes	Yes
Question 13: Overall Clarity	4.3	4.3	4	4	4	4

**5-point Likert scale: 1 = Not effective/reasonable/useful; 5 = Very effective/reasonable/useful*

- Fairly equal representation from acute care and rehab: 42% of responses were from acute care; and 54.5% of responses from rehab
- In general, no significant differences in average scores between acute care and rehab
- Acute care rated 80% (8/10) of questions as 4 or higher
- Rehab rated 90% (9/10) of questions as 4 or higher
- Average scores for acute care ranged from 3.5 – 4.7
- Average scores for rehab ranged from 3.8 – 4.6
- Rehab tended to rate the guidelines either equal to or slightly higher for 8 of the 12 questions
- Greatest difference in average scores: Question 5 (Effectiveness of guidelines in providing information about when to submit application) with acute care ratings lower by 0.8
- Lowest ratings by both acute care and rehab for Question 10 (Usefulness of having information about ALC Codes in the guidelines).

Rehab Population Groups Represented in Settings

	ABI	Amp	Burns	Cardiac	Pain	Ger.	MSK	Neuro	Onc.	Resp	S.C.I	Stroke	Trauma	Other
Acute Care	10	8	0	4	4	9	7	6	7	6	3	10	1	Sarcoma, General Surgery, Neuro Surgery, General
Rehab	3	9	2	9	2	6	11	8	5	6	3	11	5	Geriatric patients with nephrology interventions
Totals	13	17	2	13	6	15	18	14	12	12	6	21	6	

- All rehab populations represented in clinical settings of survey respondents
- Most prevalent rehab populations represented in clinical settings *(in descending order)*: Stroke, MSK, Amputee, Geriatric, Neurology, Cardiac, ABI, Oncology, Respiratory

Clinical Designation of Survey Respondents

	Discharge Planner/Case Manager	Admissions/ Service Coordinator	Allied Health: PT	Allied Health: SW	Allied Health: OT	Other
Acute Care	4	0	3	5	2	CNS (1)
Rehab	1	6	2	1	1	Physiatrist (1); Clinical Intake Coordinator (1); Team Coordinator (1); Unit Clinical Leader (2); Manager (1) Unknown (1)
Totals	5	6	5	6	3	8

5.5 Appendix 5
Inpatient Rehab Referral Guidelines (Final Draft)

The ***Inpatient Rehab Referral Guidelines*** are intended for general application across multiple rehab populations in need of **regular** or **low tolerance long duration** (i.e. slow stream) inpatient rehabilitation. To optimize the rehab referral process, these guidelines are organized around patient-specific criteria related to the determination of patients suitable for rehab, their medical stability and readiness for rehab.

The benefits of these guidelines are:

- to ensure that rehab referrals are submitted in a timely and appropriate manner
- to minimize the number of days that patients are waiting in Alternate Level of Care (ALC).

Application of **each and every component** of these guidelines should result in the submission of rehab referrals **before** a designation of ALC is made. (Further information regarding ALC designation can be found in the Appendix.)

Recognizing that each rehab program has its own set of admission criteria, **these guidelines are to be considered in their entirety** and **used in conjunction with the specified admission criteria of individual inpatient rehabilitation programs.** Detailed information about the admission criteria of individual rehab programs can be found on the GTA Rehab Network's new admission information website, ***Rehab Finder*** (see: www.gtarehabnetwork.ca).

Guideline for determining if a patient is a candidate for inpatient rehabilitation:

- ✓ Patient demonstrates by documented progress the potential to return to premorbid/baseline functioning or to increase in functional level with participation in the rehab program.
- ✓ There is reason to believe that, based on clinical expertise and evidence in the literature, the patient's condition is likely to benefit from the rehab program/service.
- ✓ Goals for rehabilitation have been established and are specific, measurable, realistic and timely.
- ✓ The patient or substitute decision-maker has consented to treatment in the program and demonstrates willingness and motivation to participate in rehab program (Exception: patients with reduced motivation/initiation secondary to diagnosis e.g. brain injury, depression).

Guideline for determining Medical Stability:

- ✓ 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 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.

Guideline for determining Rehab Readiness:

- ✓ Patient meets the criteria of a rehab candidate as defined in guideline above.
- ✓ Patient meets the criteria of medical stability as defined in guideline above.
- ✓ 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.
- ✓ Patient's special needs have been determined.
- ✓ Patient is able to meet the minimum tolerance level of rehab program as defined by the admission criteria of rehab program.
- ✓ There are no behavioural or active psychiatric issues limiting patient's ability to participate in rehab program.
- ✓ Treatment for other co-morbid illnesses/conditions does not interfere with patient's ability to participate in rehab (e.g. dialysis or active cancer treatment resulting in fatigue or frequent absences from unit during rehab treatment sessions).
- ✓ Patient's discharge options following rehab have been discussed.

Guideline for Timing of Submission of Application for Rehab:

- ✓ Patient meets the criteria of a rehab candidate as defined in the guideline above.
- ✓ Patient meets the criteria of medical stability as defined in the guideline above or patient's date of medical stability can be identified within the next 1-2 days of submission of application.
- ✓ Patient meets the criteria for rehab readiness as defined in the guideline ***or*** the date for rehab readiness can be identified.

Note: Referrers should notify rehab facilities of the cancellation of the referral in the event that the referral is no longer required (e.g. patient is accepted elsewhere).

Guideline for Number of Referrals to be Submitted:

- ✓ Organizations should send referrals to a minimum of 2-3 rehab programs as appropriate

Detailed information about the admission criteria of rehab programs can be found on the GTA Rehab Network's admission information website, ***Rehab Finder*** (www.gtarehabnetwork.ca). This web-based resource provides a comprehensive listing of all publicly-funded and fee-for-service rehab programs[5] provided by hospitals that are members of the GTA Rehab Network and community care access centres (CCACs) across the Greater Toronto Area.

Rehab Finder allows you to search for rehab programs by:

- Patient Population (including age)
- Organization
- Service Setting
- Special Needs
- Geographical Region

Information on ***Rehab Finder*** includes:

- Description of the program
- Admission and Exclusion criteria
- Application process and forms
- Information about wait list management
- Contact details

[5] Information on fee-for-service rehab programs/clinics/services in ***Rehab Finder*** will be available in fall 2005.

Guideline for Timing of Responses to Referrals:

- ✓ Responses to referrals should be given within 2 business days of receipt of application.
- ✓ Responses to referrals should be specific to one of the following response categories:
  - **Decision is pending** because:
    - i) referral form is incomplete
    - ii) patient's current status precludes a decision at this time.

  - **Referral is accepted**. (Provide estimated date of admission)

  - **Referral is accepted and waitlisted.** (Provide estimated date of admission). Reasons for waitlisting due to:
    - i) current bed availability
    - ii) current resource availability to accommodate complex patient needs
    - iii) infection control issues.

  - **Referral is declined** (Please be as specific as possible)

Appendix (to Inpatient Rehab Referral Guidelines)

Alternate Level of Care (ALC) Designation:

The following information has been drawn from the Canadian Institute for Health Information's (CIHI) Discharge Abstract Database (DAD) Abstracting Manual.[6]

- An ALC patient has finished the acute care phase of his/her treatment but remains in the acute care bed
- An ALC patient no longer requires services that must be delivered in an acute care hospital setting.

- ALC guidelines are only applicable to active treatment/acute care discharges
- ALC designation is not used for extended/chronic care, residential care, intermediate/personal care, or day care surgery cases
- ALC requires a medical decision to be made by the attending physician or authorized hospital designate to determine when the patient no longer requires acute care services
- ALC status is often identified through a collaborative interdisciplinary approach.

ALC Codes:

There are a number of diagnosis (ICD-10-CA) codes that can be applied to ALC patients. Please refer to the CIHI Discharge Abstract Data Abstracting Manual for information regarding specific coding.

[6] CIHI Discharge Abstract Data Abstracting Manual, Chapter 10:1 – 10, April 2003