GTA REHAB Network

Inpatient Rehab/LTLD Referral Guidelines

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Introduction

The ***Inpatient Rehab Referral Guidelines*** are intended for general application across multiple rehab populations in need of **high tolerance short duration** 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 timely submission of rehab referrals, preferably **at or before** ALC designation.

(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 using the admission information tool, ***Rehab Finder***, available on the GTA Rehab Network website (see: www.gtarehabnetwork.ca).

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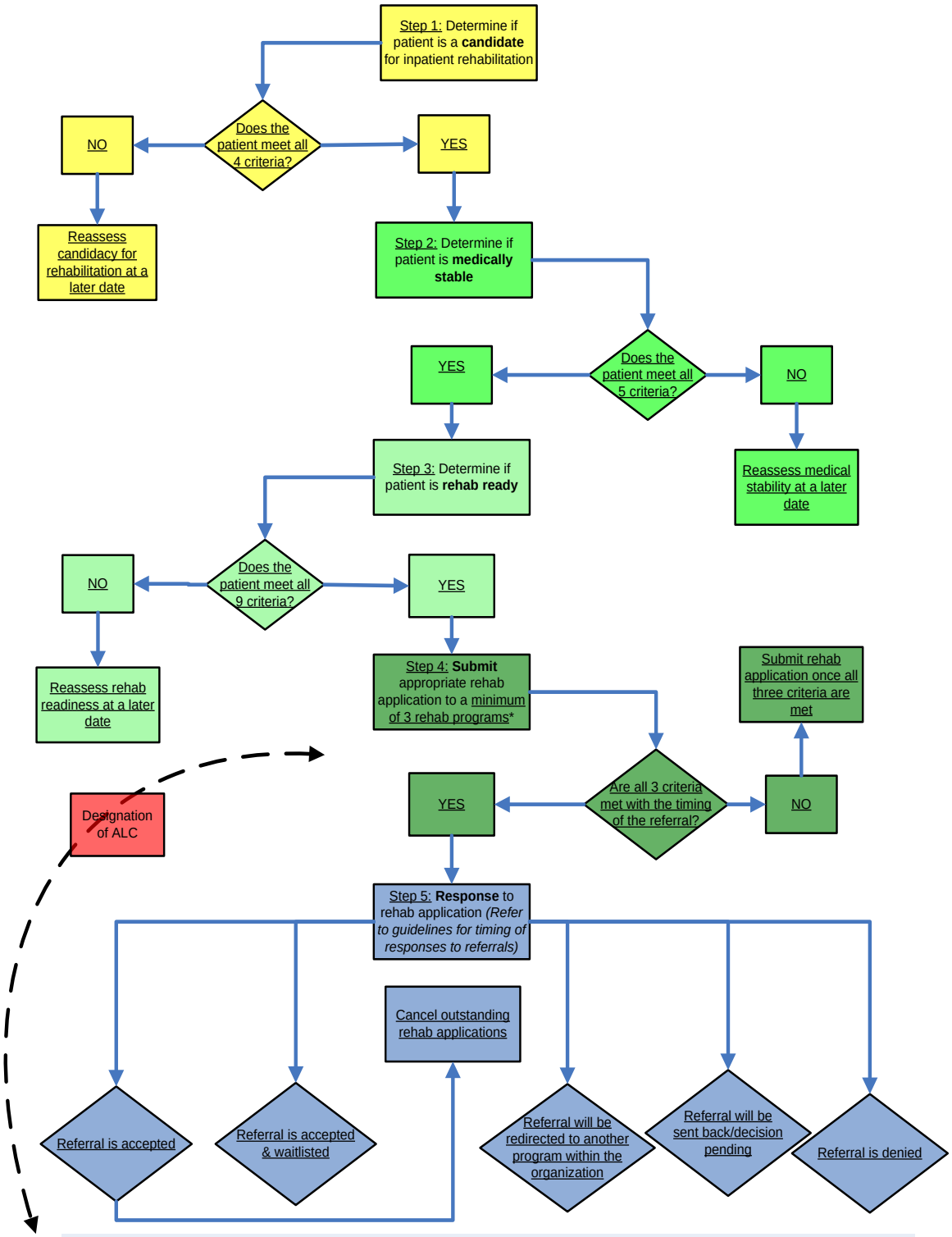
QUICK REFERENCE GUIDE FOR INPATIENT REHAB/LTLD REFERRALS



*A minimum of 3 applications may not be required in hospitals with internal rehab beds (as per organization-specific policies) or for some specialized rehab programs.

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Inpatient Rehab/LTLD Referral Guidelines

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 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 the rehab program.

  (Exception: patients with reduced motivation/initiation secondary to diagnosis e.g. brain injury, depression).

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 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.

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 the rehab program as defined by its admission criteria.
- ✓ There are no behavioural issues limiting the patient's ability to participate at the minimum level required by the rehab program.

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- ✓ There are no psychiatric issues limiting the patient's ability to participate at the minimum level required by the rehab program.
- ✓ Treatment for other co-morbid illnesses/conditions does not interfere with the patient's ability to participate in rehab (e.g. dialysis or active cancer treatment).
- ✓ Patient's discharge options following rehab have been discussed.

DETERMINING 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 above ***or*** the date for rehab readiness can be identified.

Note I: Once it is determined that a patient is rehab candidate, medically stable and the date of rehab readiness is known, the referral to rehab should be submitted. Planning for discharge should begin prior to ALC designation.

Note II: Referrers should notify rehab facilities of the cancellation of the referral in the event that the referral is no longer required.

DETERMINING NUMBER OF REFERRALS TO BE SUBMITTED …

- ✓ Organizations should send referrals to a minimum of 3 rehab programs as appropriate.[1]

Detailed information about the admission criteria of individual rehab programs can be found using the admission information tool, ***Rehab Finder***, available on the GTA Rehab Network website (see: www.gtarehabnetwork.ca).

This web-based resource provides a comprehensive listing of all publicly-funded and fee-for-service rehab programs/services provided by hospitals and community access centres that are members of the GTA Rehab Network.

[1] Please note that a minimum of 3 applications may not be required in hospitals with internal rehab beds (as per organization-specific policies) or for some specialized rehab programs.

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Rehab Finder allows you to search for rehab programs by:

- Patient Population (including age)
- Organization
- Service Setting
- Special Needs
- Local Health Integration Network

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

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

DETERMINING 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:

Referral is accepted (Provide date of admission)

Referral is accepted and waitlisted. (Provide estimated date of admission).
Reason(s) for waitlisting due to:

- Current bed availability
- Current resource availability to accommodate complex patient needs
- Infection control issues

Referral will be redirected to another program within the organization. (Provide name of program.)

Referral will be sent back and decision is pending because**:**

- referral form is incomplete
- information is insufficient/inconsistent to make a decision regarding rehab readiness
- patient's current status does not indicate rehab readiness. Update required.

Referral is denied because:

- referral is cancelled
- patient does not meet program criteria/requirements
- patient needs a secured unit
- program cannot accommodate medical needs
- program cannot accommodate behavioural issues
- program cannot accommodate psychiatric issues

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APPENDIX

Provincial Alternate Level of Care (ALC) Definition For implementation in all acute and post-acute hospitals*

(Adapted from the Wait Time Information Strategy)

Provincial ALC Definition

The healthcare system aspires to deliver care in a setting that is congruent with the clinical needs of a patient as defined by the patient's health status, treatment plan and goals.

The definition applies to all patient populations waiting in all patient care beds in an acute or post acute care hospital in Ontario.

Definition:

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC)[1] at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination[2] (or when the patient's needs or condition changes and the designation of ALC no longer applies).

*as of July 1, 2009

Note 1

The patient's care goals have been met ***or***

- progress has reached a plateau ***or***
- the patient has reached her/his potential in that program/level of care ***or***
- an admission occurs for supportive care because the services are not accessible in the community (e.g. "social admission").

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

Note 2

Discharge/transfer destinations may include, but are not limited to:

- home (with/without services/programs),
- rehabilitation (facility/bed, internal or external),
- complex continuing care (facility/bed, internal or external),
- transitional care bed (internal or external),
- long term care home,
- group home,
- convalescent care beds,
- palliative care beds,
- retirement home,
- shelter,
- supportive housing.

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

Final Note

The definition **does not** apply to patients:

- waiting at home,
- waiting in an acute care bed /service for another acute care bed/service (e.g., surgical bed to a medical bed),
- waiting in a tertiary acute care hospital bed for transfer to a non tertiary acute care hospital bed (e.g., repatriation to community hospital).

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