Rehabilitative Care Alliance

Rehab Transitions Self-Assessment Tool

Recently, the Rehabilitative Care Alliance (RCA) System Evaluation task group identified a quality improvement initiative to support patient transitions from hospital to in-home rehab. This work was identified after a review of the RCA provincial System Performance data and a priority ranking exercise.

The working group, which consisted of former patients, care partners and clinical representatives, was convened and identified key issues in transitions from hospital to in-home rehab through the completion of a root cause analysis, process map, best practices review, environmental scan, stakeholder interviews and in-depth group discussions.

The working group activities illustrated the importance of the **timely transfer of essential patient information at the point of transition from hospital to in-home.**

To help, we've created a Self-Assessment tool for clinicians, practice leads, managers and decision-makers to ensure essential patient information is conveyed to the in-home rehab team when a patient transitions from hospital to in-home rehab. It is intended to serve as a Self-Assessment tool that can be referenced by individuals, organizations or Ontario Health Teams to promote the transfer of pertinent patient information that is timely and relevant to support the assessment and treatment of patients at the first in-home rehab visit.

Clinicians can complete the self-assessment to help identify areas of further development in their clinical practice, whereas organizational teams can use the results to develop Quality Improvement plans (QIPs) and/or Collaborative Quality Improvement Plans (cQIPs). The content of the Self Assessment Tool was developed with a rehabilitative care lens and has been aligned with the Ontario Health Quality Standard Statements on Transitions from Hospital to Home, the Senior Friendly Care framework and the ALC Leading Practices guide.

USING THE TOOL:

Users can reflect on the OH Quality Standard and the Minimum Information Needed to Support Rehab Transition and select the appropriate status.

Met	You/Your organization can objectively measure and demonstrate that the practice has been implemented and **sustained**. The practice occurs more than 80% of the time.
Partial	You/Your organization has taken SOME steps towards implementing the practice. The practice occurs between 60-80% of the time.
Unmet	You/Your organization has taken NO steps towards implementing the practice. The practice being assessed occurs less than 60% of the time.
Not Applicable (N/A)	This indicator is not applicable.

Ontario Health Quality Standard Statement 2: Comprehensive Assessment

People receive a comprehensive assessment of their current and evolving health care and social support needs. This assessment is started early upon admission, and updated regularly throughout the hospital stay, to inform the transition plan and optimize the transition process

Minimum Information Needed to Support Rehab Transition	Overall Assessment of this Practice		Supporting Information
Minimum Admission and Referral Information Required at Transition	Status	Implementation notes	Validation (Data, Forms, Processes, etc.)
The reason for hospital admission is included in discharge summaries and referral to in-home rehab ▪ *include relevant medical history*	Select		
Reason for referral to in-home rehab service(s) is included in discharge summaries and referral to in-home rehab sf, ALC-LP ▪ *as specific as possible*	Select		
Minimum Medical Information Required at Transition	Status	Implementation notes	Validation (Data, Forms, Processes, etc.)
Relevant medical information for in-home rehab is included in discharge summaries and referral to in-home rehab sf, ALC-LP ▪ *delirium, wounds, palliative status, co-morbidities)*	Select		
Relevant physician's orders are documented and included in discharge summaries and referral to in-home rehab ▪ *weight-bearing status, activity restrictions, contraindications*	Select		
Minimum Safety/Functional Information Required at Transition	Status	Implementation notes	Validation (Data, Forms, Processes, etc.)
Functional status information is included in discharge summaries and referral to in-home rehab sf, ALC-LP ▪ *mobility, transfers, equipment, cognition, communication, swallowing*	Select		
Patient safety responses are included in discharge summaries and referrals to in-home rehab sf, ALC-LP ▪ *ability to call 911, access to emergency alert*	Select		

Ontario Health Quality Standard Statement 3: Patient, Family, and Caregiver Involvement in Transition Planning

People transitioning from hospital to home are involved in transition planning and developing a written transition plan. If people consent to include them in their circle of care, family members and caregivers are also involved.

sf – in alignment with Senior Friendly Care
ALC-LP – in alignment with the Alternative Level of Care Leading Practices Guide

Minimum Information Needed to Support Rehab Transition	Overall Assessment of this Practice		Supporting Information
Minimum information shared about in-home support available	Status	Implementation notes	Validation (Data, Forms, Processes, etc.)
Support available is included in discharge summaries and referral to in-home rehab sf, ALC-LP ▪ *family, friends, community supports, and amount of support available (daily, weekly, or as required)*	Select		
The key care partner/support person's name and phone number is included in discharge summaries and referral to in-home rehab ▪ *substitute decision-maker, if required*	Select		

Ontario Health Quality Standard Statement 8: Coordinated Follow-Up (Medical and Rehabilitative Care)

People transitioning from hospital to home have follow-up medical care with their primary care provider and/or a medical specialist coordinated and booked before leaving the hospital. People with no primary care provider are provided with assistance to find one.

Minimum Information Needed to Support Rehab Transition	Overall Assessment		Supporting Information
Minimum discharge information shared at the transition	Status	Implementation notes	Validation (Data, Forms, Processes, etc.)
The rehab provider's name and contact information is available ▪ *key contact information for the rehab provider is available to facilitate warm handover*	Select		
Follow-up information relevant to the patient's rehab in the first 7 days post-discharge is included in discharge summaries and referral to in-home rehab sf, ALC-LP ▪ *names and phone numbers of community services the patient may be expecting to hear from and what to do if they do not hear within a specified window*	Select		

Ontario Health Quality Standard Statement 10: Out-of-Pocket Costs and Limits of Funded Services

People transitioning from hospital to home can pay for any out-of-pocket health care costs considered by the health care team, and information and alternatives for unaffordable costs are included in transition plans. The healthcare team explains to people what publicly funded services are available to them and what services they will need to pay for.

Minimum Information Needed to Support Rehab Transition	Overall Assessment		Supporting Information
Minimum information about equipment and rehab services shared transition	Status	Implementation notes	Validation (Data, Forms, Processes, etc.)
Equipment needs and what has been communicated to the patient are included in discharge summaries and referral to in-home rehab sf, ALC-LP ■ *equipment costs/rental costs and process are explained to the patient and care partner* ■ *update on the status of equipment is provided to the in-home rehab provider*	Select		

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ALC-LP – in alignment with the Alternative Level of Care Leading Practices Guide