November 2019

Transfer of Rehabilitative Care (TRC) Processes At-A-Glance: for Mississauga Halton LHIN Staff

Patient with a Stroke

CVH: 1D ONLY (go-live Nov. 18, 2019)
OTMH (go-live date & units TBD)
If patient requires **any rehabilitation service (OT; PT; SLP; Dietitian; or SW) with Home and Community Care** upon discharge home

Patient Profile

Patient residing and receiving care within Mississauga Halton LHIN

New or existing patient with stroke

Hospital Therapist(s)/Discharge Planner: Completes one TRC Form & any relevant discharge paperwork

- Shares TRC Form & paperwork with Mississauga Halton LHIN hospital team
- Provides Patient Rehab Summary Form to the patient

LHIN Hospital Care Coordinator (CC)/Team Assistant (TA):

1. Receives TRC Form & discharge paperwork. Manages CHRIS file under usual processes
2. Files: (a) TRC Form in CHRIS under **Transfer of Rehabilitative Care Form** name & (b) other discharge documents under usual processes
3. CC completes interRAI CA; team sends appropriate service offers to rehab SPO(s)
4. Shares TRC Form & discharge paperwork through HPG with initial service offer, specifying that **TRC is being shared** in the provider notification

If TRC provided to LHIN hospital team after service offer(s) sent:

- Hospital team shares TRC form with the referred rehab SPO(s), specifying that TRC Form is being shared in the provider notification
  - If hospital team not able to share TRC Form with Rehab SPO in exceptional circumstance, then: tasks LHIN community team to share TRC Form with Rehab SPO entering in provider notification to Rehab SPO that TRC Form is attached

Goal

To improve comunication between therapists across transitions of care

Exclusion:
OT Pre-Discharge Assessment

SPO therapist(s): receive referral, hospital discharge paperwork including TRC Form & schedules initial assessment with patient; reviews TRC Form, using it in practice

Ontario