November 2019

Transfer of Rehabilitative Care (TRC) Processes At-A-Glance: for Rehabilitation Service Provider Organizations

Patient with Stroke

In hospital, requiring rehabilitation services upon hospital discharge
CVH: 1D only (go-live Nov. 18, 2019); OTMH (go-live date & units TBD)

At home, receiving in-home rehabilitation services through Home and Community Care with a Rehab Service Provider Organization (SPO) **(go-live Nov. 18, 2019)**

Hospital Therapist/Discharge Planner: Completes TRC Form & discharge paperwork
- Shares TRC Form & paperwork with Mississauga Halton LHIN hospital team
- Provides Patient Rehab Summary Form to the patient

Patient Profile

Patient residing and receiving care within Mississauga Halton LHIN

New or existing patient with stroke

LHIN Hospital Care Coordinator (CC)/Team Assistant (TA):
- Receives TRC Form & discharge paperwork. Manages CHRIS file under usual processes
- Files **(a) TRC Form in CHRIS under Transfer of Rehabilitative Care Form** and (b) other discharge documents under usual processes
- CC completes interRAI CA; team sends appropriate service offers to rehab SPO(s)
- Shares TRC Form & discharge paperwork through HPG with initial service offer, specifying "**TRC is being shared**" in 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 TRC being shared in provider notification

Goal

To improve communication 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

When patient is ready for discharge from in-home rehabilitation services, the SPO therapist makes either clinical decision:

Scenario 1

Discharged from rehabilitation services; patient does not require further rehabilitation from another program. **SPO therapist:**
- Discharges as per regular process, sending Patient Service Report to the Mississauga Halton LHIN

OR

Scenario 2

Discharged from in-home rehabilitation, but referred to another rehabilitation program (e.g., outpatient clinic; community program). **SPO therapist:**
- Completes discharge paperwork as appropriate **& a new TRC**
- Provides Patient Rehab Summary Form to the patient
- Shares new and any previous TRCs completed with new program where patient is being referred
- Sends Patient Service Report as usual process to Mississauga Halton LHIN. ****DOES NOT SEND TRCs to the LHIN**

Ontario