Transfer of Rehabilitative Care Form

FREQUENTLY ASKED QUESTIONS

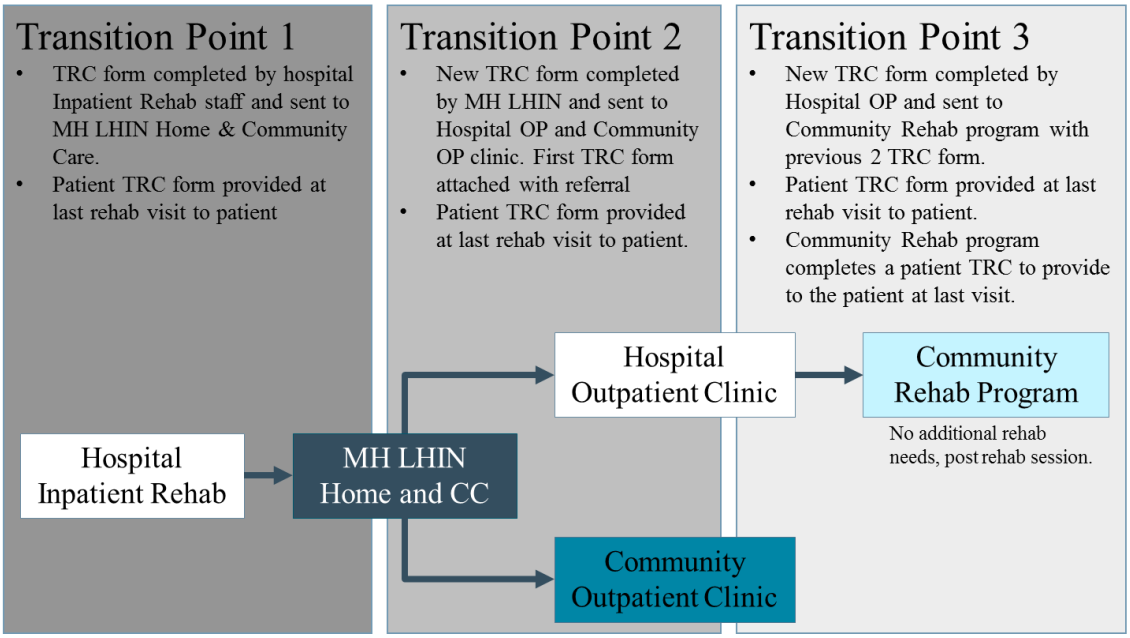
1. **What's the benefit of using a Transfer of Rehabilitative Care Form?**
   The Transfer of Rehabilitative Care (TRC) form addresses a common gap within our system of the lack of information around patient care shared across rehab providers involved in providing services to the patient throughout the patient journey.

   <u>The Problem:</u>
   - This current information gap puts a strain on the receiver of a rehab referral to contact the sender to get more information on the patient to prepare for the client appointment.
   - In turn, the receiving program therapists might have to ask the patient questions about their rehab/medical history, leaving the patient frustrated and with a poor experience.
   - Sometimes the type of information that is shared is not relevant or consistent across the various rehab providers.
   - There is a lot of time and effort spent on trying to find the right information by calling the sending organization back multiple times.
   - When making an outpatient rehab referral therapists have to look through receiving rehab program specific referral forms and requirements that vary by organization, again leading to more time being spent looking for information and completing different forms with different information needs per organization.

   <u>The Solution:</u>
   - The TRC form addresses this information gap by ensuring there is one common rehab referral form that is used for all outpatient rehab programs supported by an allied staff. These outpatient rehab programs can be offered in the community or hospital. The TRC form will eliminate the need to look for organization specific rehab referral forms through the use of one commonly accepted rehab form (TRC) for all publicly funded rehab programs. This included all hospital outpatient/ambulatory rehab clinics and community rehab programs supported by allied staff.

   - The TRC form is to be used for recording patient information specific to admission and discharge, separate discharge documents are not required when using a TRC form.

   - The TRC form will allow rehab providers to consistently get the same rehab information for their patients and allows for each TRC form at each transition point to be shared with the receiving program. Please see example below:



In its current state the TRC will be implemented in a manual paper based environment with future technology e-referral/record management platforms to be explored.

2. **When should a Transfer of Rehabilitative Care Form (TRC) be used?**
A TRC for is to be used when making a rehab referral to any outpatient program in the hospital, home care, and/or community supported by allied health staff. It is a therapist to therapist referral such as Physiotherapists (PT), Occupational Therapists (OT), Speech Language Pathologists (SLP), Dietician, Social Worker (SW) etc.

   If rehab goals have been met and no additional rehab referral to other programs is needed then a TRC should not be completed.

   The TRC form should not be completed for OT pre-discharge assessment, usually requiring 1-2 home visits or for referrals to private therapists, community support program not offered through allied supported staff, and or rehab programs not funded by the Ministry of Health or Mississauga Halton LHIN.

3. **When should the Patient Transfer of Rehabilitative Care Form be used?**
The Transfer of Rehabilitative Care initiative has been developed keeping the patient experience in mind as well allowing for a common vehicle (form) to be used between rehab providers to share important patient information to address the information gap. Having patients at the center of our planning, it is very important that the patient version (1 page form) be used at the last patient visit or at time of discharge from a rehab program. The purpose of the patient TRC for is to:
   - Provide a paper copy or record to the patient about their rehab goals
   - If another transfer of rehab care is required provide information on the referral made
   - Have the patient use this form for their own record management and note taking (page 2 of the patient TRC form)

4. **How is the Transfer of Rehabilitative Care Form completed? On paper or electronically?**
The TRC form is completed based on each organization's current referral systems and processes. The form will be provided in a paper format and electronically where drop down lists can be used with ease to save time. We understand that currently all health service provider organizations have different referral systems and most organizations use fax as the preferred method for transmitting a

referral. If you have the ability to use the form electronically we recommend you do that since it will make it easier and saves time to complete with the Drop Down options, allowing the opportunity to copy and paste information from other patient information systems like meditech. However, we understand that not all staff have a lap top with them all the time and therefore will need to complete the form in a manual paper format, therefore we have provided two versions of the form 1) manual paper based 2) electronic with drop down and copy and paste options. A form reference guide and quick reference guide including all outpatient rehab programs with fax numbers is also provided in the toolkit to help therapists in processing the referral once completed.

5. How many people and who should complete the Transfer of Rehabilitative Care (TRC) form?

Depends on the rehab program and the rehab service delivery model. There are different models out there in hospitals and community, programs are either delivered via single discipline or through a multidisciplinary team model. If it is a single discipline then the most responsible discipline providing patient care will be responsible to complete the form and send it to the receiver. If it's a multidisciplinary team approach then each discipline can complete their specific sections of the form, communicate within the team that they have completed their sections on the TRC form and the last person responsible for providing treatment or care to the patient will complete the remaining sections and send the form to the next rehab provider.

6. There is no place for a physician to sign off on the Transfer of Rehabilitative Care (TRC) form? How do I capture a physician signature if required?

The Transfer of Rehabilitative care form is to be used for all outpatient, home care and/or community rehab programs publicly funded and supported by allied staff. A physician signature in most cases should not be required. However, we understand for some cases a physician signature might be required based on specific rehab populations, or where an outpatient program requires it based on an organization's discharge practice or policy to address a particular patient's care needs. In such circumstances the physician order form would be part of a physician order set and can be attached on the last page of the TRC form page 4 of 4, under "Attachments".

7. How long will the TRC pilot be? And how will it be evaluated?

The Transfer of Rehabilitative Care pilot is planned to begin in Nov, 2019. The pilot will last 3-4 months, where it will be evaluated and any necessary changes will be made to the TRC form. Any pilot sites using the TRC form will continue to use the form with suggested changes post pilot evaluation; while the project team prepares a regional implementation plan to ensure all remaining rehab provider organizations can implement the TRC form moving forward.

The pilot will be evaluated at a 3 month (mid pilot) and at pilot end check point through a survey monkey that will be developed by the project team and administered by the project team through your Health Service Provider site champions. The objective of the 3 month check in survey is to ensure that if there are any immediate issues/challenges with the TRC form impacting patient care, they are mitigated before continuing with the remaining duration of the pilot. A patient survey on the TRC will also be administered by the HSPs, and will be provided to the patients at their last rehab visit or within 1 week of program discharge. The patient survey is developed by the project team and all responses on the patient survey will be analyzed and assessed by the project team at the end of the pilot.

8. What if I have questions on the TRC project who should I talk to?

The project is being led by the Regional Programs Portfolio at The Mississauga Halton LHIN. The project lead is Amy Khan who can be reached at amy.khan@lhins.on.ca. However, to ensure that staff at all participating organizations are fully supported throughout the pre-pilot "training and

education” phase and through the 3-4 month pilot life cycle, we have identified Health Service Provider (HSP) site champions at each participating rehab organization. These HSP site champions will be your main point of contact throughout the pilot and will be available to address any questions you might have on the TRC pilot. The HSP site leads work closely with the LHIN project team to ensure that all questions are addressed in a coordinated and timely manner and any issues/risks flagged with an appropriate mitigation strategy in place. Please see below for details around the roles and responsibilities for an HSP site champion.