

T o r o n t o

**Acquired
Brain Injury**
N e t w o r k

ABI Inpatient Rehab Referral Guidelines

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INTRODUCTION

The **ABI Inpatient Rehab Referral Guidelines** are based on the GTA Rehab Network's Inpatient Rehab Referral Guidelines (see: http://www.gtarehabnetwork.ca/referral_guide.asp) and are specifically intended for application across acquired brain injury rehab regular or slow stream inpatient rehabilitation programs.

To optimize the rehab referral process, these guidelines are organized around patient-specific criteria related to the determination of patients suitable for ABI 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 ensure that the right referral is being directed to the right program
- to minimize the number of days that patients are waiting in Alternate Level of Care (ALC).

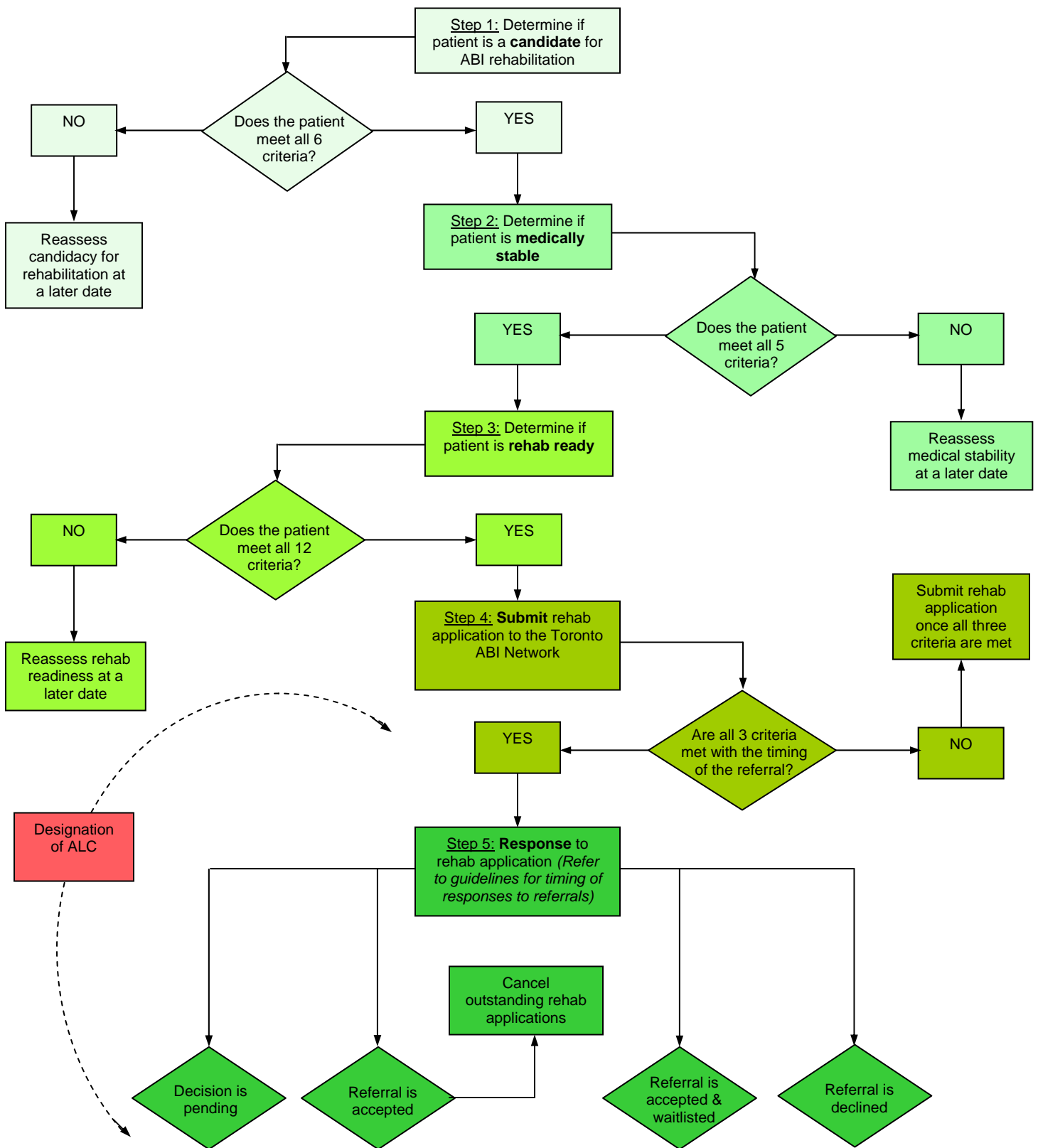
Application of **each and every component** of these guidelines should result in the submission of rehab referrals **before** a designation of ALC is made.

Recognizing that each organization 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 organization's ABI rehabilitation programs.**

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

Applications for ABI rehab and other ABI related information can be found on the Toronto ABI Network website (see: www.abinetwork.ca).

QUICK REFERENCE GUIDE FOR ABI REHAB REFERRALS



INPATIENT REHAB

INPATIENT REHAB REFERRAL GUIDELINES

Step 1: Determining if a patient is a candidate for ABI inpatient rehabilitation ...

- 1.1. Patient has a diagnosis of acquired brain injury (*see Appendix 1*)
- 1.2. Patient demonstrates cognitive impairment (if there is no cognitive impairment, individual may be more appropriate from a general rehab or a neuro rehab program)
- 1.3. Patient demonstrates by documented progress the potential to increase in functional level with participation in rehab program.
- 1.4. There is reason to believe that, based on clinical expertise and/or evidence in the literature, the patient's condition is likely to benefit from the rehab program/service.
- 1.5. Goals for rehabilitation have been established and are specific, measurable, realistic and timely.
- 1.6. The patient or substitute decision-maker has consented to treatment in the program and demonstrates willingness and motivation to participate in rehab program. (Exception: patients with reduced motivation/initiation secondary to diagnosis e.g. brain injury, depression).

Step 2: Determining Medical Stability ...

- 2.1 A clear diagnosis and co-morbidities have been established.
- 2.2 At the time of discharge from acute care, acute medical issues have been addressed; disease processes and/or impairments are not precluding participation in rehab program.
- 2.3 Patient's vital signs are stable.
- 2.4 No undetermined medical issues (e.g. excessive shortness of breath, falls, congestive heart failure).
- 2.5 Medication needs have been determined.

Step 3: Determining Rehab Readiness ...

- 3.1. Patient meets the criteria of an ABI rehab candidate as defined in guideline above.
- 3.2. Patient meets the criteria of medical stability as defined in guideline above.
- 3.3. 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.
- 3.4. Patient's special needs have been determined and can be met by rehab programs as per organization specific eligibility criteria (see GTA Rehab Network's *Rehab Finder*: www.gtarehabnetwork.ca/RehabFinder.asp)
- 3.5. Patient is able to meet the minimum tolerance level of rehab program as defined by the admission criteria of rehab program (i.e., x for regular stream rehab and y for slow stream rehab).
- 3.6. There are no active psychiatric issues limiting patient's ability to participate in rehab program.
- 3.7. Any behaviour secondary to the brain injury can be managed within the rehab program's environment/resources (e.g., patient may wander but could be managed within a secure unit).
- 3.8. Patient does not require an observer or the cost of the observer can be covered by external sources (e.g., the patient's automobile insurer).
- 3.9. Patient does not require physical restraints (i.e., any risk of fall could be mitigated by low beds or other safety precautions).
- 3.10. Treatment for other co-morbid illnesses/conditions does not interfere with patient's ability to participate in rehab (e.g. dialysis or active cancer treatment resulting in fatigue or frequent absences).
- 3.11. Patient's discharge options following rehab have been discussed.
- 3.12. Patient has a Rancho Los Amigos Scale (*see Appendix 2*) score of ≥ 5 for regular stream and ≥ 4 for slow stream rehab.

Step 4: Determining Timing of Submission of Application for Rehab ...

- 4.1. Patient meets the criteria of a rehab candidate as defined in the guideline above.
- 4.2. 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 few days after submitting the application (consideration should be given to length of wait list for ABI beds in determining when to send in application).
- 4.3. Patient meets the criteria for rehab readiness as defined in the guideline above or the date for rehab readiness is expected within a reasonable time frame (relative to the wait list for ABI at the time of submission) based on demonstrated progress since injury/illness.

Note I: Referrers should notify the Toronto ABI Network of the cancellation of the referral in the event that the referral is no longer required (e.g. patient is accepted elsewhere or no longer needs inpatient rehab).

Note II: Timing of ALC designation is based on patient meeting the criteria for rehab candidacy, medical stability and rehab readiness.

Step 5: Determining Timing of Responses to Referrals ...

- 5.1 The Toronto ABI Network will advise of receipt of application within 24 hours and indicated expected wait based on current wait list.
 - **Referrer will be notified if referral is incomplete and will not be forwarded until all required information is obtained by the Network office.**
 - **Depending on length of wait list or change in patient status, referrer may be asked to forward updates**
- 5.2 Application will be forwarded to one rehab facility when next available bed is identified or pending with consideration given to patient preference.
- 5.3 Responses to referrals should be given within two business days of rehab facility receiving application.
- 5.4 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). Reasons for wait listing due to:
 - Current resource availability to accommodate complex patient needs (e.g., needs secure unit and no beds available on that unit at present)
 - Infection control issues
 - **Referral is declined** (Please be as specific as possible)
 - Facility may hold referral and request updates if progress is expected

APPENDIX 1: DEFINITION OF ACQUIRED BRAIN INJURY

An acquired brain injury is damage to the brain which occurs after birth and is not related to:

- a congenital disorder
- a developmental disability or
- a process which progressively damages the brain.⁽¹⁾

The damage may be caused:

- traumatically (i.e., from an external force such as a collision, fall, assault or sports injury)
- through a medical problem or disease process which causes damage to the brain (internal process or pathology).⁽²⁾

(1) Congenital Development Problems:

(not considered ABI)

- Cerebral Palsy
- Autism (Pervasive Developmental Disorder)
- Developmental Delay
- Down's Syndrome (21 Chromosomal Abnormalities)
- Spina Bifida with hydrocephalus
- Muscular Dystrophy

Progressive Processes/Diseases:

(not considered ABI)

- Alzheimer's Disease
- Pick's Disease
- Dementing Processes
- Amyotrophic Lateral Sclerosis
- Multiple Sclerosis
- Parkinson's Disease and Similar Movement Disorders
- Huntington's Disease

(2) Non-Traumatic Causes of ABI:

- Anoxia
- Aneurysm and Vascular Malformations
- Brain Tumours
- Encephalitis
- Meningitis
- Metabolic Encephalopathies
- Stroke with Cognitive Disabilities (eligibility for service may depend on clients needs/goals)

APPENDIX 2: RANCHO LOS AMIGOS: LEVELS OF COGNITIVE FUNCTIONING

I. No Response

Patient appears to be in a deep sleep and is unresponsive to stimuli.

II. Generalized Response

Patient reacts inconsistently and non-purposefully to stimuli in a nonspecific manner. Reflexes are limited and often the same, regardless of stimuli presented.

III. Localized Response

Patient responses are specific but inconsistent, and are directly related to the type of stimulus presented, such as turning head toward a sound or focusing on a presented object. He may follow simple commands in an inconsistent and delayed manner.

IV. Confused-Agitated

Patient is in a heightened state of activity and severely confused, disoriented, and unaware of present events. His behaviour is frequently bizarre and inappropriate to his immediate environment. He is unable to perform self-care. If not physically disabled, he may perform automatic motor activities such as sitting, reaching and walking as part of his agitated state, but not necessarily as a purposeful act.

V. Confused-Inappropriate, Non-Agitated

Patient appears alert and responds to simple commands. More complex commands, however, produce responses that are non-purposeful and random. The patient may show some agitated behaviour it is in response to external stimuli rather than internal confusion. The patient is highly distractible and generally has difficulty in learning new information. He can manage self-care activities with assistance. His memory is impaired and verbalization is often inappropriate.

VI. Confused-Appropriate

Patient shows goal-directed behaviour, but relies on cueing for direction. He can relearn old skills such as activities of daily living, but memory problems interfere with new learning. He has a beginning awareness of self and others.

VII. Automatic-Appropriate

Patient goes through daily routine automatically, but is robot-like with appropriate behaviour and minimal confusion. He has shallow recall of activities, and superficial awareness of, but lack of insight to, his condition. He requires at least minimal supervision because judgment, problem solving, and planning skills are impaired.

VIII. Purposeful-Appropriate

Patient is alert and oriented, and is able to recall and integrate past and recent events. He can learn new activities and continue in home and living skills, though deficits in stress tolerance, judgment, abstract reasoning, social, emotional, and intellectual capacities may persist.

*Original Scale co-authored by Chris Hagen, Ph.D., Danese Malkmus, M.A., Patricia Durham, M.A.
Communication Disorders Service, Rancho Los Amigos Hospital, 1972.*

APPENDIX 3: ALTERNATE LEVEL OF CARE (ALC) DESIGNATION

The following information has been drawn from the Canadian Institute for Health Information's (CIHI) Discharge Abstract Database (DAD) Abstracting Manual.⁽³⁾

An ALC patient:

- ✓ has finished the acute care phase of his/her treatment but remains in the acute care bed
- ✓ no longer requires services that must be delivered in an acute care hospital setting
 - ALC guidelines are only applicable to active treatment/acute care discharges
 - ALC designation is not used for extended/chronic care, residential care, intermediate/personal care, or day care surgery cases
 - ALC requires a medical decision to be made by the attending physician or authorized hospital designate to determine when the patient no longer requires acute care services
 - ALC status is often identified through a collaborative interdisciplinary approach

ALC codes:

There are a number of Diagnosis (ICD-10-CA) codes that can be applied to ALC patients. Please refer to the CIHI Discharge Abstract Data Abstracting Manual for information regarding specific coding.

An ALC patient in rehab:

- ✓ has finished active rehabilitation but remains in a rehabilitation bed (this is not based on length of stay criteria)
 - no longer has rehab goals
 - is no longer making progress towards goals
- ✓ no longer requires services from a rehabilitation hospital but unable to be discharged to the next level of care

(3) CIHI Discharge Abstract Data Abstracting Manual, Chapter 10:1 – 10, April 2003