Backgrounder

Timely Transfer of Appropriate Patients from Acute Facilities to Rehabilitation:
Using the AlphaFIM® Instrument to Support Best Practice in Stroke Care

Use of the AlphaFIM Instrument is recommended provincially and nationally as a best practice in acute stroke care for all stroke admissions.

What is the AlphaFIM® ("AlphaFIM") Instrument?

The AlphaFIM Instrument is designed to provide a consistent method of assessing patient disability and functional status in the acute care hospital setting.

It consists of six items that can be reliably collected in acute care: *Eating, Grooming, Bowel Management, Toilet Transfers, Expression,* and *Memory*. For patients who are able to walk 150 feet or more, the *Eating* and *Grooming* items are replaced by items evaluating *Walking* and *Bed Transfers*.

Results provide an AlphaFIM score (see table), with higher numbers indicating higher function, and an estimate of the patient's 'burden of care' in hours. The AlphaFIM assessment is completed by credentialed, registered health care professionals, primarily rehabilitation and nursing staff.

Why Implement the AlphaFIM Instrument?

To Objectively Determine Appropriate Discharge Destination and Enhance Patient Flow:

An AlphaFIM score can help determine where a patient would be best served after acute treatment is complete and can expedite triage to rehabilitation.

It is one component for consideration in discharge planning. An AlphaFIM score provides objective data regarding disability and stroke severity as well as facilitate the transfer of information to the rehabilitation setting.

Triage Guidelines*

AlphaFIM Score		Recommended Referral
Mild	> 80	Community-based rehabilitation
Moderate	40 to 80	Inpatient rehabilitation
Severe**	< 40	Admit to inpatient rehabilitation, if eligible, OR consider an alternate program (e.g. restorative care /short term complex medical) with regular assessment for admission to inpatient rehabilitation

*The AlphaFIM score is only **one** component for consideration in discharge planning
** Refer to *Backgrounder on Access to Rehab for Severe Stroke*

To Participate in Provincial Recommendation for Acute Stroke Care:

Use of the AlphaFIM Instrument is recommended provincially and nationally as a best practice[1] in acute stroke care for all stroke admissions. The Provincial Stroke Reference Group has made recommendations to the Ministry of Health and Long Term Care through the Rehabilitation and Complex Continuing Care Expert Panel which include the completion of the AlphaFIM assessment on all patients with stroke **on** Day 3 post acute hospital admission. In 2007, the Ontario Stroke System recommended to support the provincial implementation and use of the AlphaFIM Instrument in acute care to determine the stroke survivor's functional status and impairments. Use of the AlphaFIM Instrument in the acute setting will facilitate linking data with the National Rehabilitation Reporting System (NRS) dataset where the FIM® Instrument (Functional Independence Measure) data are collected. AlphaFIM scores will become part of the common language and practice in Ontario.

How are AlphaFIM data collected, evaluated and applied?

As of October 2014, AlphaFIM data is collected by the Canadian Institute for Health Information in the Discharge Abstract Database.

Characteristics of adult patients with stroke who received AlphaFIM assessments for 2010/11*		
	% of sample	Mean AlphaFIM score
Mild Disability	43.8%	100.7
Moderate Disability	31.3%	60.3
Severe Disability	24.9%	25.8
	*data collected from 2,201 charts from 47 Ontario acute care hospitals	

A recent study[3] from the Toronto Stroke Networks concluded that:

- The AlphaFIM Instrument was a valuable tool for triaging stroke patients from acute care to rehabilitation
- The AlphaFIM score predicted functional status at discharge from rehabilitation
- Patients with low AlphaFIM scores had the potential to make significant functional gains and should not be denied admission to inpatient rehabilitation programs.

Stroke care system gaps and strengths can be identified through analyzing the AlphaFIM data on a provincial and regional basis.

How does an organization implement the AlphaFIM Instrument?

For those considering implementation, the steps include:

- connecting with your Regional AlphaFIM Lead
- arranging for early identification of all stroke admissions
- identifying staff to be trained and credentialed as assessors
- determining the documentation process
- ensuring access to the web-based software portal to convert raw ratings into projected scores

For more information on implementing the AlphaFIM Instrument in your organization, please contact:

Regional Stroke Rehabilitation Coordinator, AlphaFIM Lead
Stroke Network of Southeastern Ontario:
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 Or Ontario Stroke Network   www.ontariostrokenetwork.ca or
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> *Support is available for implementation and clinician credentialing in acute care hospitals.*
>
> *Each Ontario Regional Stroke Network:*
>
> - *holds a license granting acute care hospitals the ability to use the AlphaFIM Instrument exclusively for people with stroke*
> - *monitors credentialing*
> - *has a designated individual to act as the "AlphaFIM Lead"*
> - *provides access to on-line tools to support implementation & training*

References:

1. Lindsay, M.P., Gubitz, G., Bayley, M., Hill, M.D., Davies-Schinkel, C., Singh, S., and Phillips S. (2010). *Canadian Best Practice Recommendations for Stroke Care (Update 2010). On behalf of the Canadian Stroke Strategy Best Practices and Standards Writing Group*. Ottawa, ON: Canadian Stroke Network. Retrieved from www.strokebestpractices.ca.
2. Hall, R., Khan, F., O'Callaghan, C., Kapral, MK., Hodwitz, K., Fang, J., and Bayley, M. (2012). *Ontario Stroke Evaluation Report 2012: Prescribing System Solutions to Improve Stroke Outcomes: Ontario Stroke Report Card, 2010/11*. Toronto, ON: Institute for Clinical Evaluative Sciences. Retrieved from http://www.ices.on.ca/file/Stroke_Evaluation_Report_2012.pdf
3. Lo, A., Tahair, N., Sharp, S., and Bayley, MT. (2012). Clinical utility of the AlphaFIM® Instrument in stroke rehabilitation. *International Journal of Stroke,* 7(2), 118-124.

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