

Using the AlphaFIM® Instrument to Support Timely Transfer of Appropriate Patients from Acute Facilities to Rehabilitation

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

Results provide an AlphaFIM® score, 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 healthcare professionals, including Occupational Therapists, Physiotherapists, Speech-Language Pathologists and nursing staff.

The AlphaFIM® is an abbreviated version of the Functional Independence Measure® (FIM®) instrument, where only 6 tasks are assessed for each client.

To Objectively Determine the 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 of many components for consideration in discharge planning (see table below).

An AlphaFIM® assessment provides objective data regarding disability and stroke severity, and facilitates the transfer of information to the rehabilitation setting.

Triage Guidelines

Provincial Recommendation for Acute Stroke Care:

Use of the AlphaFIM® instrument is recommended provincially and nationally as a best practice¹ in acute stroke care for all stroke admissions. The standard of practice is the completion of the AlphaFIM® assessment on all patients with stroke **on or by Day 3 (TARGET DAY 3)** post acute hospital admission.

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

For more information on obtaining your credentialing on the AlphaFIM® instrument in your organization, please email Donna Cheung at donna.cheung@uhn.ca.

References:

1. Boulanger JM, Lindsay MP, Stotts G, Gubitz G, Smith EE, Foley N, Bhogal S, Boyle K, Braun L, Goddard T, Heran MKS, Kanya-Forster N, Lang E, Lavoie P, McClelland M, O’Kelly C, Pageau P, Pettersen J, Purvis H, Shamy M, Tampieri D, vanAdel B, Verbeek R, Blacquiére D, Casaubon L, Ferguson D, Hegedus J, Jacquin GJ, Kelly M, Linkewich B, Mann B, Milot G, Newcommon N, Poirier P, Simpkin W, Snieder E, Trivedi A, Whelan R, Smitko, E, Butcher K. On behalf of the on Behalf of the Acute Stroke Management Best Practice Writing Group, and the Canadian Stroke Best Practices and Quality Advisory Committees; in collaboration with the Canadian Stroke Consortium and the Canadian Association of Emergency Physicians. In Lindsay MP, Gubitz G, Dowlatshahi D, Harrison E, and Smith EE (Editors) on behalf of the Canadian Stroke Best Practices Advisory and Quality Committees. Canadian Stroke Best Practice Recommendations, 2018; Ottawa, Ontario Canada: Heart and Stroke Foundation. Retrieved from www.strokebestpractices.ca.

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