Background and Purpose. This administrative case report documents the development of a mechanism by which systematic triage was used to assign patients to therapists in acute care settings. The primary objective was to develop a triage tool to improve patient access to medically necessary therapy services.

Case Description. A unique triage tool and a decision tree were developed to determine which patients referred to therapists for acute care therapy required skilled services. The triage tool was used to examine therapy referrals for patients from 2 large academic hospitals; 6 criteria were used to determine which evaluations should be cancelled. During the trial period, the predictive ability of individual triage criterion items was analyzed, the tool was modified and validated, and a decision tree was established. Descriptive and chi-square analyses were performed on all variables of interest.

Outcomes. The systematic triage system reduced the number of therapy evaluations that were not appropriate by 29%, resulting in an improvement in the availability of therapy services for patients who required skilled care. The average number of patients per therapist per workday decreased from 18.9 to 12.1 and from 15.1 to 12.8 in the 2 hospitals. An improvement in a newly developed “workload index” related to missed patient visits also indicated the success of this project.

Discussion. A novel systematic triage system reduced the number of therapy evaluations that were not appropriate, resulting in an improvement in the availability of therapy services for patients who require skilled intervention.
Reducing expense in the US health care system is of paramount importance.1–2 Many people no longer believe that the United States has the best health care system in the world.3–5 In fact, the US health care system is the most expensive in the world.6,7 The United States spends more on health care than other industrialized nations, and those countries provide health insurance to all of their citizens.7 In 2008, total US health care spending was $2.4 trillion dollars, or $7,900 per person, representing 17% of the gross domestic product.8

Medicare does not reimburse for nonskilled therapy and states, "Services that can be safely and effectively furnished by nonskilled personnel or by PTAs [physical therapist assistants] or COTAs [certified occupational therapy assistants] without the supervision of therapists are not rehabilitative therapy services."9 Therapy staffing resources are increasingly limited. In 2007, the American Hospital Association cited a therapist vacancy rate of 11.4%; this rate far exceeded the vacancy rate for registered nurses, which was approximately 8.1%.10 That study also indicated a significantly higher percentage of hospitals reporting increased difficulties in recruiting to fill vacancies in 2006 when compared with 2005.

Many types of waste exist in the US health care system, and the waste of overproduction1 is among the most common affecting therapy practices. Bush defined the waste of overproduction as "producing what is unnecessary, when it is unnecessary, and in an unnecessary amount."11(p873) Some examples of overproduction waste in therapy practices include (1) performing "gait training" when a patient requires only standby assistance and the nursing staff is already "walking" with the patient in the hallway and (2) providing passive range of motion for a patient who is in an intensive care unit and chemically sedated, who does not have abnormal tone, and for whom nursing staff are performing range-of-motion activities during hygiene activities. These activities may be considered nonskilled services and a waste of resources.9

Recent changes in the health care environment have affected the roles and responsibilities of most, if not all, health care professionals. Changes in the health care environment include expanding regulatory demands,9 new models for patient care, management restructuring, pressures for cost containment, and increased productivity measurements.11–15 In a study conducted to evaluate the impact of these changes, Blau et al11 found that physical therapists reported feeling a loss of control, stress, discontentment, and disheathment. The authors noted, "One factor was the coupling of increased patient load with decreased time available for examination and treatment of each patient. This combination led to an overwhelming feeling of busyness and a burdensome feeling of never reaching work-related goals."11 Increased numbers of patients, increased documentation demands, and reduced support staff also were found to contribute to therapists’ perceived levels of stress.11(pp652–655) Changes in the health care environment at our institution include ongoing implementation of an electronic medical record system, changes in documentation requirements driven by regulatory agencies, and increased scrutiny related to productivity expectations. Examples of recent changes related to roles include enhanced keyboard skill requirements, the application of autonomous practice principles and direct-access models, and the use of advanced technology systems and equipment.

Research suggests that factors producing a negative work experience, such as stress, will likely produce negative outcomes or lower levels of job satisfaction and commitment to an organization.16–18 In a 2002 study, Lopopolo19 reported that employee stress may be caused by role overload, which occurs when an employee perceives that too much is expected of him or her in the performance of the job. This form of stress can contribute to organizational problems, which can lead to a diminution in employee and organizational performance.19 Broom and Williams20 also found that increased clinical workload caused stress that negatively affected therapists both personally and professionally.

In many acute care settings, a percentage of patients referred to therapists either may not require skilled therapy services at all or should have these services deferred to a later date. Allowing these referrals to be added to therapists’ caseloads results in the inefficient use of resources, a potential liability risk for patients who are not seen, and staff dissatisfaction that may result in burnout. Therapists have reported feelings of burnout related to the ethical dilemma of determining which patients take precedence when the demands for care exceed what can be provided.21 Although difficult, limiting the provision of health care often is necessary21–25; in the current health care environment, such limitation may occur in therapy services.

Patients in acute care hospitals may not receive adequate therapy interventions (as determined by impair-
Triage of patients referred for therapy services in acute care settings is a difficult, yet imperative, task. Unfortunately, there is a dearth of research describing specific strategies for triage of patients who require physical therapy and occupational therapy services in acute care settings. As health care resources decline while the demand for therapy services increases, optimizing care delivery through triage will be of utmost importance.

This report documents the development of a mechanism by which systematic triage was used to assign patients to therapists in acute care settings. The goal of this project was to decrease the number of patients who were assigned to therapists’ caseloads but did not need skilled therapy services. At our institution, value is defined as quality (outcomes, safety, and service) in relation to the cost of care over time.26 A unique triage tool and a decision tree were developed to quantitatively determine which patients referred to therapists for acute care therapy require skilled services.

Target Setting

The target settings for this project were 2 acute care hospitals that are part of a single academic health care organization. Hospital A is licensed for 1,157 beds, and hospital B is licensed for 794 beds. Hospital A is designated as a level one trauma center that deals with a wide variety of diagnoses. Hospital B primarily serves patients with cancer, transplant, obstetric, and elective joint replacement diagnoses. The 2 hospitals are located approximately 1.6 km (1 mile) from each other in the same community. The therapy practices at both hospitals are part of the physical medicine and rehabilitation department at the institution and are supported by a common leadership team. The acute care practice of hospital A is typically staffed with 38 physical therapists, 8 physical therapist assistants, 33 occupational therapists, and 9 occupational therapy assistants. Hospital B usually is staffed with 10 physical therapists, 2 or 3 physical therapist assistants, and 3 occupational therapists on a daily basis. On a typical day, hospital A has a caseload ranging from 295 to 430 patients, and hospital B has a caseload of 70 to 90 patients. The departmental leadership team consisted of physical therapists and occupational therapists, with 2 therapy directors, 6 therapy supervisors, and 7 assistant supervisors. An inpatient rehabilitation unit and outpatient practices area were not included in the scope of this project.

Many acute care practices have caseloads of patients to manage rather than prescheduled visits, and the management of such caseloads is often difficult. In the 2 target hospitals, the caseloads of patients were larger than the available therapy staff could manage sufficiently. Some patients were receiving less care than they required, whereas others were receiving care that likely could have been provided by another discipline or a family member. Therapists’ productivity was negatively affected because of time spent reviewing medical records and performing evaluations for patients who did not require skilled therapy services. Complaints from referring providers about delayed therapy services or a lack of therapy services were being received. Therapy staff also voiced stress and frustration about their inability to meet the needs of all patients on their caseloads.

The inadequate provision of patient care and inefficiencies associated with the existing state of subjective triage negatively affected many stakeholders, including patients, families, referring physicians, nurses, therapists, and the therapy leadership team. Academic medical centers experience a constant influx of new and rotating referring providers. Previous attempts to educate all referrers in the skill of appropriate referral were ineffective because of the frequent rotation of resident staff. The therapy leadership team determined that the optimal way to deal with these concerns was to develop a triage system.

Development of the Process

Rehab Innovation and Optimization Team

This project was developed by 4 therapist managers who oversee both physical therapy and occupational therapy practices, along with a physiatrist from a large physical medicine and rehabilitation department. These individuals were enrolled in an intense education and training program on quality improvement methods. In our institution, therapy managers are responsible for leadership of both physical therapist and occupational therapist practices regardless of their professional education. The group was entitled the “Rehab Innovation and Optimization Team” (RIOT). The RIOT was charged with addressing the lack of consistency in triage of referrals to acute care physical therapy and occupational therapy and reducing the volume of referrals that did not meet Centers for Medicare and Medicaid Services (CMS) standards for medical necessity in acute care settings;
the aim was to improve access to medically necessary therapy services for patients who require skilled therapy services. A series of surveys, triage tools, and a decision tree were developed by the 4 therapist leaders and the physiatrist, with input from staff physical therapists and occupational therapists practicing in the acute care settings of both hospitals.

Inclusion Criteria
All referrals for acute care inpatient therapy services were included, with the exception of those from specialty practice areas whose referrals were known to almost always call for skilled therapy services. Many of these areas have established protocols or referral criteria. It was believed that the yield from applying the triage tool to these referrals would be quite low and would be an inefficient use of resources. Excluded were referrals from orthopedics, physiatry, pediatrics, psychiatry, and pulmonology; referrals for hand therapy; referrals for wound or lymphedema management; and referrals for therapy after selective denervation for torticollis.

Caseload Measurement
For the establishment of baseline metrics, the numbers of patients on therapists' caseloads and missed visits were recorded. These data were compared with the numbers of therapists available to treat patients. A “workload index” was developed and used to determine the approximate number of patients on each therapist's caseload. The number of patients (N) on the caseload plus the number of newly referred patients that day (R) divided by the number of therapists (T) represented the workload index (WI): WI=(N+R)/T.

This workload index was not validated for the purpose of the quality improvement initiative reported here but does have face validity for measuring the average demand on a therapist’s time.

Triage Tool Development
Criteria were proposed by all members of the RIOT, resulting in an extensive list of possible reasons why a patient would not require skilled therapy services. Discussion sessions were used to solicit input from staff therapists at each hospital to verify what they were experiencing. From a comprehensive list of items, those that were believed to be most predictive of patients requiring skilled therapy services were selected in accordance with the CMS definition of medical necessity for the initial triage tool.9 According to the CMS, the elements of medical necessity for therapy services include the following: adherence to acceptable standards of practice; a level of complexity and sophistication that only a qualified therapist or someone under the direction of a therapist can achieve; an intervention that will lead to significant improvement in a reasonable time frame; and the establishment of functional maintenance programs, when appropriate.9 The tool was further refined through an iterative process. For operationalization of the triage process, a decision tree was developed (Fig. 1).

This project included a comprehensive review of 246 medical records. This review was part of the iterative process through which the triage tool for clinical decision making was developed. Rapid cycle testing is a management tool used to quickly determine the effectiveness of changes being implemented. This quick evaluation allows the determination of effectiveness before too much change occurs.27 This method was selected so that multiple versions of the tool could be tested with quick repeat testing periods before implementation. The initial instrument, Triage Tool I, comprised 13 criteria (Appendix 3). The option “defer” was omitted from Triage Tool III because it was determined to be subjective and thus not predictive of a patient’s need for skilled therapy services.

Additional rapid cycle testing was conducted for 56 referrals over a 2-day time frame to validate the process through which the triage tool could be tested with quick repeat testing periods before implementation. The initial instrument, Triage Tool I, comprised 13 criteria (Appendix 3). During the first testing period, 20 consecutive reviews were completed to evaluate this version of the instrument. An item analysis of the elements revealed that 5 criteria were redundant, were too vague, or did not contribute to the recommendation by the person performing triage to cancel or defer the referral. Thus, a revised triage tool, Triage Tool II, was developed; this version included 8 criteria (Appendix 2).

During a 1-week beta testing period for Triage Tool II, 2 therapist leaders screened all referrals that met inclusion criteria (N=170). No consults were actually cancelled or deferred during this testing period. On the basis of the record review, a recommendation about the appropriateness of therapy services was made. The recommendation was not communicated to the evaluating therapist, thus reducing bias related to the screening process. Details about the items on the triage tool that would have resulted in cancellation or deferral of the referral were noted.

Two additional project team members subsequently reviewed the evaluating therapist’s documentation because all consults were allowed to progress to a therapist caseload. This review validated that the tool correctly recommended cancellation 100% of the time (Table). In addition, the predictive ability of the individual triage items was analyzed with the JMP statistical software package, version 7.0.1* (Table). Two criteria were determined to be insignificant in predicting the appropriateness of skilled therapy services, resulting in Triage Tool III. The new tool consisted of 6 predictive criteria (Appendix 3). The option “defer” was omitted from Triage Tool III because it was determined to be subjective and thus not predictive of a patient’s need for skilled therapy services.

Additional rapid cycle testing was conducted for 56 referrals over a 2-day time frame to validate the

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* SAS Institute Inc, 100 SAS Campus Dr, Cary, NC 27513-2414.
dictive ability of Triage Tool III (Table). The triage and record review processes described above were repeated. An analysis of the results validated that the tool correctly recommended cancellation 100% of the time. None of the referrals for which the recommendation was cancellation were for patients who required skilled therapy services. After validation of the triage tool, a decision tree was developed (Fig. 1).

**Application of the Process**

Once Triage Tool III was validated, the triage process was implemented at both hospitals. Initially, 2 of the therapist leaders from the RIOT performed all of the triage at both locations. They worked to streamline the process, focusing on defining the most efficient steps for reviewing electronic medical records. The therapist leadership team members from both hospitals were educated on the use of the decision tree. Each leader practiced using the decision tree with feedback from the other RIOT team member until they achieved 100% agreement about whether to proceed to evaluation or to cancel. It took members of the team approximately 3 to 5 minutes to review each referral with the triage process. Once the process was established, education about the new process and the rationale was presented to referring providers, nurse managers, and social workers at both hospitals.

**Outcome**

When a referral was deemed inappropriate, the referring provider was contacted to explain the rationale for cancellation. If additional information indicating the need for an evaluation was obtained during the discussion with the referring provider, the evaluation was scheduled. If no additional information warranting an evaluation was obtained, the referral was cancelled. If a patient’s needs were not evident despite the use of the decision tree, the patient was placed on the therapist’s caseload.

Two key metrics were workload index and number of missed visits. These metrics improved during this project (Figs. 2 and 3).
Discussion

In the current health care environment of ever-increasing costs and limited resources, optimization of the impact that physical therapists and occupational therapists have on patient outcomes in acute care settings is critical. One step toward such optimization is limiting the number of inappropriate referrals on therapists’ caseloads.

Through the iterative development of a triage tool, the RIOT successfully standardized the triage of referrals for physical therapy and occupational therapy in acute care settings. Other clinical settings may benefit from the development of similar systems as well. The RIOT also achieved the key goal of reducing the number of inappropriate assignments of patients to therapists’ workloads. Additional validation of the newly developed triage tool will be performed annually. Although the triage tool was validated for this project as described earlier, patient populations and therapy practices may change over time. In such situations, the tool may require additional development and subsequent revalidation.

The workload index developed for this project represented the demand of patient volume relative to the supply of therapists. The workload index and the number of missed visits per therapist per day decreased at both hospitals. At hospital A, approximately 24% of planned visits were missed each day before the RIOT implementation, and only 4% were missed after.
the implementation. At hospital B, missed visits declined from 2% of planned visits to less than 1% after full implementation.

Much higher proportions of therapy referrals at hospital A than at hospital B were included in the scope of this project. Hospital B had a primarily orthopedic caseload, which was excluded. The number of missed visits was somewhat subjective because, when patient volumes were high, visits might have been abbreviated because of a lack of therapist time rather than completely missed. This scenario might have artificially reduced the number of missed visits during the baseline measurement period and therefore biased the results for the measured impact of the RIOT project toward null.

Staff satisfaction was not quantitatively measured during this project. The use of a validated staff satisfaction tool to measure the impact of the new triage system might have enhanced this project. We acknowledge the relationship between stress caused by heavy workloads and the potential for staff dissatisfaction.19,20

Each therapist leader brought to the triage process a unique set of values related to his or her beliefs, experience, application of deductive logic, emotion, and intuition.28 We believe that we minimized the resulting potential bias, to some extent, by focusing on the CMS definition of medical necessity and the critical assessment of each patient’s potential to engage in a meaningful therapy session. We also acknowledge that organizational goals often are valued less than personal and professional goals.29 The process of completing rapid cycle testing aided in reducing the variability among leaders and in focusing on organizational goals.

The implementation of the novel triage process has enabled therapists to spend additional time providing billable services rather than spending time on triage. Therapist productivity and net revenue have improved as a result of this process. No decline in volumes of appropriate referrals has been experienced. Institutional leadership has acknowledged the success of this project and has endorsed the process for permanent use.

The gains realized through triage were not achieved without cost. There was a trade-off in efficiency, because this process added work for therapist managers and required approximately 3 to 5 minutes per referral. Therapy evaluations, including medical record review, evaluation of the patient, and documentation, might take 30 to 90 minutes. We believe that the initial investment of managers’ time for triage outweighed the therapists’ time performing unnecessary evaluations, but this notion was not formally measured. When patients did not require skilled therapy services, the managers educated the referring providers about appropriate referrals and alternatives to meet the patients’ needs.

Changes in referral habits were not an original goal because referral habits were beyond the scope of this project. Triage leaders have observed fewer medically unnecessary referrals since the inception of this project, although these observations have not been quantitatively measured. Despite the education sessions provided to multiple stakeholders before implementation, concerns were occasionally voiced when referrals were cancelled in the early phase of implementation. When the rationale was explained, acceptance of the triage process was reached. Some providers readily agreed that a referral was inappropriate without discussion.

Initially, some nursing personnel voiced concerns about their ability to provide all services necessary for best patient care, including mobilization. These concerns were linked to a lack of understanding about the requirements for skilled therapy services. To mitigate these concerns, we held discussions with nurse managers to define services that were within the scope of nursing practice in contrast to services that required a physical therapist or occupational therapist. Nursing staff members also were invited to in-services covering topics such as range of motion, safe transfers of patients, and mobilization techniques. Several months after implementation, no concerns have been raised, and there appears to be acceptance of the process. The recent institutional emphasis on quality improvement, value, and reducing waste may have contributed to acceptance.

Stakeholder satisfaction was not measured quantitatively during this project. The use of a validated satisfaction tool to measure the impact of
the new triage system might have enhanced this project. Input from stakeholders such as social workers, nurses, and referring physicians might have provided better insight into concerns that could have been addressed earlier.

This project took place in a large academic medical center but may be applicable to other settings. Medical necessity has the same definition regardless of the practice setting. Ease of deployment may depend on existing relationships with referring providers and their understanding of skilled therapy services. Communication with stakeholders was a challenging task in the large hospitals in this project but is critical for this type of project to be successful.

Therapists with more-manageable caseloads may have the ability to spend more time caring for patients with greater needs. Thus, the application of systematic triage systems in the delivery of therapy services to patients while maintaining the highest level of quality is essential. Although the RIOT project had a positive impact on the provision of therapy services, additional evaluations are in progress to quantify the necessity of skilled therapy services for patients who are already on therapists’ caseloads. Such efforts should continue to improve the efficiency of services provided by therapists and thus maximize finite resources and reduce unnecessary costs for the health care system.

All authors provided concept/idea/research design, writing, data analysis, and project management. Dr Hobbs, Ms Boysen, Dr McGarry, and Dr Nordrum provided data collection and facilities/equipment. Dr Nordrum provided clerical/secretarial support. Ms Boysen, Dr McGarry, Dr Thompson, and Dr Nordrum provided consultation (including review of manuscript before submission).

This report was granted exempt status by the Mayo Clinic Institutional Review Board. A portion of the information contained in this report was given as a platform presentation at the Combined Sections Meeting of the American Physical Therapy Association; February 17–20, 2010; San Diego, California.

This article was submitted May 22, 2009, and was accepted June 1, 2010.


References

19 Lopopolo RB. The relationship of role-related variables to job satisfaction and commitment to the organization in a restructured hospital environment. Phys Ther. 2002;82:984–999.
21 Nordrum J, Sissola S. A generational storm: preparing for ethical and financial challenges in health care as the “boomers” retire. Presented at: Minnesota American Physical Therapy Association Fall Conference; October 12, 2007; Duluth, Minnesota.
Appendix 1.
Triage Tool I (13 Items)

Referral Date:
Patient MC #: Referring Service: Room #:
Data Collector: Diagnosis:

Yes No N/A

1. □ □ □ Does the patient have a D/C order to an SNF within 48 hours (exception: dysphagia evaluations)?

2. □ □ □ If this is a dysphagia referral, the patient
   a. □ is intubated or sedated
   b. □ has EGD pending
   c. □ is currently or was previously seen by SLP
   d. □ is able to sit at least 1 hour tid

3. □ □ □ Does the referral fail to meet criteria for skilled therapy intervention as required by regulatory agencies?

4. □ □ □ Could services be provided at a nontherapist skill level instead of a PT or OT level?

5. □ □ □ Will therapy intervention be irrelevant to the patient’s return to a prior level of function because of spontaneous recovery (eg, medication, infection, metabolic imbalance, dehydration)?

6. □ □ □ Is the patient unable to participate in therapy (eg, sedated, agitated, combative, inadequate cognition, significant change in medical status)?

7. □ □ □ Does the patient have test(s) or consult(s) pending that may affect the ability to participate in therapy (eg, VQ scan, venous Doppler scan, cardiac enzymes, MRI, CT, bone scan)?

8. □ □ □ Is there a need for attempts to mobilize the patient prior to therapy referral?

9. □ □ □ Is the patient at baseline functional status?

10. □ □ □ Is the patient already being monitored by PM&R?

11. □ □ □ Was the patient admitted less than 24 hours ago?

12. □ □ □ Is this a referral for equipment only (eg, toilet tongs, walker, exercise bike, compression stockings)?

13. □ □ □ Is the referral inappropriate for another reason? (Please note:)

Carefully evaluate the information gathered. If you responded “yes” to any of the questions, then consider marking the consult as “hold” and notifying the referral source. If the patient will not benefit from therapy services during this episode of care, then remove the patient’s name from the work list and contact the referral source.

Yes No
□ □ Was this referral inappropriate?

Recommendation: □ Cancel □ Defer

*MC=medical chart, N/A=not applicable, D/C=discharge, SNF=skilled nursing facility, EGD=esophagogastroduodenoscopy, tid=3 times per day, SLP=speech-language pathology, PT=physical therapy, OT=occupational therapy, VQ=ventilation-perfusion, MRI=magnetic resonance imaging, CT=computerized tomography, PM&R=Physical Medicine and Rehabilitation.
Appendix 2.
Triage Tool II (8 Items)*

Referral Date:

Patient MC #: Referring Service: Room #:

Data Collector: Diagnosis:

Yes No N/A

1. ☐ ☐ ☐ Does the patient have a D/C order to an SNF within 48 hours (exception: dysphagia evaluations)?

2. ☐ ☐ ☐ If this is a dysphagia referral, the patient
   a. ☐ is intubated or sedated
   b. ☐ has EGD pending
   c. ☐ is currently or was previously seen by SLP
   d. ☐ is able to sit at least 1 hour tid

3. ☐ ☐ ☐ Will therapy intervention be irrelevant to the patient’s return to a prior level of function because of spontaneous recovery (eg, medication, infection, metabolic imbalance, dehydration)?

4. ☐ ☐ ☐ Is the patient unable to participate in therapy (eg, sedated, agitated, combative, inadequate cognition, or significant change in medical status)?

5. ☐ ☐ ☐ Does the patient have test(s) or consult(s) pending that may affect the ability to participate in therapy (eg, VQ scan, venous Doppler scan, cardiac enzymes, MRI, CT, bone scan)?

6. ☐ ☐ ☐ Is there a need for attempts to mobilize the patient prior to therapy referral?

7. ☐ ☐ ☐ Is the patient at baseline functional status?

8. ☐ ☐ ☐ Is this a referral for equipment only (eg, toilet tongs, walker, exercise bike, compression stockings)?

Carefully evaluate the information gathered. If you responded “yes” to any of the questions, then consider marking the consult as “hold” and notifying the referral source. If the patient will not benefit from therapy services during this episode of care, then remove the patient’s name from the work list and contact the referral source.

Yes No
☐ ☐ Was this referral inappropriate?

Recommendation: ☐ Cancel ☐ Defer

*MC = medical chart, N/A = not applicable, D/C = discharge, SNF = skilled nursing facility, EGD = esophagogastroduodenoscopy, SLP = speech-language pathology, tid = 3 times per day, VQ = ventilation-perfusion, MRI = magnetic resonance imaging, CT = computerized tomography.
Appendix 3.  
Triage Tool III (6 Items)

Patient MC #: Referring Service: Nursing Station:
Data Collector: Referral Date:

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1. □ □ If this is a dysphagia referral, answer this question only: Is the patient ready to participate (eg, is not intubated or sedated, has no EGD pending, is not a speech therapy patient [currently or in past], and is able to sit for at least 1 hour)?

2. □ □ Are there plans to discharge the patient to an SNF within the next 48 hours (exception: dysphagia evaluations)?

3. □ □ When appropriate, have there been attempts to mobilize or walk the patient prior to therapy referral (eg, walk the patient in the hallway or to the bathroom, transfer the patient to a chair)?

4. □ □ Will the therapy intervention be relevant to the patient’s return to a prior level of function (eg, medication, infection, metabolic imbalance, dehydration)?

5. □ □ Is the patient able to participate in therapy (reasons not able to do so include: sedated, agitated, combative, inadequate cognition, significant change in medical status, bed rest, incomplete pertinent testing)?

6. □ □ Is the patient at the baseline level of function?

Cancel | Do Not Cancel

□ □ Considering the answers to the above questions, would you cancel or not cancel?

* MC = medical chart, EGD = esophagogastroduodenoscopy, SNF = skilled nursing facility.