Rehabilitative Care Alliance

Frail Senior/Medically Complex Priority Initiative Decision Tree
March 2015

STEP#1 – Early Identification/Screening

Is the patient High Risk?
NOTE: Risk determined through clinical judgement and/or **AUA** score (generally a score of 5 or 6 indicates high risk)

YES

NO

Share Results of Screen with Primary Care Provider
- **If Low Risk (i.e. 1 or 2 on AUA) consider referral(s) to local services to support:**
  - ✓ Health status prevention and maintenance strategies (e.g. preventative medical care, maintenance of function)
- **If Medium Risk (i.e. 3 or 4 on AUA consider referral(s) to local services to support:**
  - ✓ Identification and management of medical/mental health complexities (including medication adherence/ polypharmacy)
  - ✓ Assessment of the need for community and/or in-home services [i]

STEP #2 –ASSESSMENT To Determine Need for Bedded Level of Care: Arrange for Completion of a Comprehensive Clinical Assessment by a Healthcare Provider(s) with Geriatric Expertise that Considers the Geriatric Syndromes and Baseline & Current Functional Status including:

Confirmation that patient is "High Risk"

YES

NO

- **Share Results of Screen with Primary Care Provider highlighting need for urgent comprehensive assessment**
- **Identification and management of medical and/or mental health complexities**
- **Focus of interventions should be supported navigation and transitions**
- **Link with family**
- **LTC discussion** [i]

***Does the patient have Restorative Potential?**

YES

Is there an acute, medical cause for the patient's functional decline? (TBD by Primary Care/ED Practitioner)
- **Checklist to Rule-Out an Acute Cause of Functional Decline**

YES → Consult Primary Care Provider urgently for medical care

NO

STEP #3 – Streamlined Referral (RCA FS/MC Priority Process Referral Map)
In consideration of suggested **RCA Priority Process Timelines** and available services, send completed referral form (**Provincial Referral Standard**) to the most appropriate "Lead Provider" (as identified in collaboration w LHIN partners). The Lead Provider will:

1. Confirm that the patient eligible for a bedded level of rehabilitative care [iii]
   - **RCA Definitions Framework - Eligibility Criteria for Bedded Levels of Rehabilitative Care** [ii]

NO → Consult CCAC urgently for assessment for alternate level of care

2. Determine most appropriate level of bedded Rehabilitative Care
   - **RCA Definitions Framework**

3. Communicate admission decision to referrer/centralized intake

Other Tools
- **RCA Priority Process Evaluation Indicators**

[i] Assessment Urgency Algorithm (AUA): Phase 1 Report: Exploring the use of the AUA screener in the ED to identify seniors at risk of frailty (April 8, 2014)
[ii] As per Rehabilitative Care Alliance definition of Restorative Potential
[iii] Rehabilitative Care Alliance Definitions Framework (2014)