Frail Senior/Medically Complex
Final Report Recommendations for LHINs and HSPs
March 2015
Presentation Overview

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The Rehabilitative Care Alliance (RCA) is a provincial collaborative that was established by Ontario’s 14 LHINs in April 2013 with a two-year mandate to effect positive changes in rehabilitative care that focus on supporting improved patient experiences and clinical outcomes and enhancing the adoption and effectiveness of clinical and fiscal priorities.
What is “rehabilitative care”?

“Rehabilitative Care” is a broad range of interventions that result in the improved physical, mental and social wellbeing of those suffering from injury, illness or chronic disease.”

RCA priority areas of focus

DEFINITIONS - Provide clarity for patients, families and referring professionals through the development of common terminology, clear definitions and standards of practice for all levels of rehabilitative care across the continuum.

CAPACITY PLANNING & SYSTEM EVALUATION - Support monitoring and evaluation of rehabilitative care services, programs and system performance through development of a standard rehabilitative care capacity planning and evaluation toolkit.

FRAIL SENIOR / MEDICALLY COMPLEX - Develop a rehabilitative care approach for frail senior/medically complex populations to support operationalization of priority elements of the “Assess and Restore Framework to Support Aging in Place”.

Priority areas of focus

OUTPATIENT / AMBULATORY - Inform evaluation and planning at the provincial, regional, organizational and program levels through development of a comprehensive and standardized minimum dataset for outpatient/ambulatory rehabilitation and a mechanism for collection, analysis and sharing of the data.

PLANNING CONSIDERATIONS FOR RE-CLASSIFICATION OF CCC/REHAB BEDS - Identify current issues related to the re-classification of CCC to inpatient rehabilitation beds across the province and provide advice and direction on the development of a Re-classification Toolkit that outlines considerations and provides an analysis of implications in a systemic and standardized manner.

Work on these priorities was achieved through dedicated cross-functional task and advisory groups for each priority.
Alignment with other system priorities

The work of the RCA aligns with and builds upon Ministry of Health and Long-Term Care priorities and directions and other province-wide initiatives.

Work on the five priorities was informed by evidence and data, as available, and by extensive provincial stakeholder engagement and input into the final deliverables.
RCA Priority: Frail Senior/Medically Complex
Gap/Issue identified

- The report ‘Living Longer, Living Well’ was released in December 2012 which included a description of an ‘Assess and Restore Framework to Support Aging in Place’ and recommendations related to ‘Enhanced Screening and Detection of Functional Loss’ and ‘Enhanced Assess and Restore Services Provision’ intended to support the development of the Assess and Restore Framework.

Sinha, S. *Living Longer, Living Well*. Highlights and Key Recommendations from the Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a Seniors Strategy for Ontario (December, 2012).
Sinha, S. Living Longer, Living Well. Highlights and Key Recommendations from the Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a Seniors Strategy for Ontario (December, 2012).

www.rehabcarealliance.ca
Gap/Issue identified

• In response to the ‘Assess and Restore Framework’, the MOHLTC developed an Assess and Restore Guideline\(^\text{ii}\), which was released in December 2014, and which outlines expectations and defines the roles and responsibilities of LHINs, HSPs, and care providers in delivering Assess and Restore interventions across five areas: screening, assessment, navigation and placement, care delivery, and transitions home.

Gap/Issue identified

• Concurrently, in the spring/summer of 2013, the RCA was engaging rehabilitative care system stakeholders to develop the work plan and deliverables for the RCA’s first two-year mandate.

• The Frail Senior/Medically Complex (FS/MC) Task and Advisory Groups were given the mandate to develop a rehabilitative care approach for frail senior/medically complex populations to support operationalization of the Assess and Restore Framework.
Deliverables

1. Standardized ‘Provincial Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED’. This process includes three steps:
   
i. Early Identification/Screening,
ii. Assessment to Determine Need for Bedded Rehabilitative Care, and
iii. Streamlined Referral.

Implementation of the ‘Priority Process’ will require local contextualization of the standard process in consideration of available community resources.
Provincial Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED

### Step #1
Early Identification/Screening

<table>
<thead>
<tr>
<th>Where</th>
<th>Community</th>
<th>ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>CCAC</td>
<td>CSS</td>
</tr>
</tbody>
</table>
| When  | Referral for ADL/IADL support  
|       | A change in functional status  
|       | Part of 90 day re-Ax            | A change in functional status  
|       |                                      At time of check-up  
| How   | Assessment Urgency Algorithm (AUA)/CLINICAL IMPRESSION | Upon presentation with functional impairment(s) |

- If the screen identifies the patient as being ‘high risk’
- The assessment in Step #2 is to be completed collaboratively with Primary Care, SGS & other involved community providers

### Step #2
Assessment to Determine Need for Bedded Rehabilitative Care

Note: Where already involved, consider consulting members of the community allied ID team to support assessment

<table>
<thead>
<tr>
<th>Who</th>
<th>CCAC</th>
<th>Specialized Geriatric Services</th>
<th>Primary Care Provider(s)</th>
</tr>
</thead>
</table>
| What  | Arrange for Completion of a Comprehensive Clinical Assessment by a Healthcare Provider(s) with Geriatric Expertise that Considers the Geriatric Syndromes and Baseline and Current Functional Status including:  
|       | A. Confirmation that Patient is “High Risk”  
|       | ✓ Recent ADL/functional decline  
|       | ✓ Risk of needing ED, hospital or LTC if nothing is done  
|       | B. Confirmation of Restorative Potential  
|       | C. Ruling Out an Acute Medical Cause of Functional Decline w Primary Care/ED Practitioner |

Complete Referral Form and Send to Most Appropriate “Lead Provider” (as identified in collaboration w LHIN partners) who will lead/navigate Step #3.

### Step #3
Streamlined Referral

<table>
<thead>
<tr>
<th>Lead Provider*</th>
<th>Centralized Intake</th>
<th>Receiving Bedded Rehabilitative Care Provider</th>
</tr>
</thead>
</table>
| What           | A. Confirm patient is eligible for bedded level of Rehabilitative Care  
|                | B. Determine most appropriate level of bedded Rehabilitative Care     |

**NOTE:** Expedited “priority” access may be considered for patients who present to ED or are anticipated to imminently require institutionalization

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1 Denotes potential Lead Provider. LHINs may identify another organization/group to lead Steps #3 based on local resources

1 As per definition provided in “Specialized Geriatric Services - Review Template” (July 7, 2014), Ministry of Health and Long-Term Care (MOHLTC)

2 As per Rehabilitative Care Alliance definition of ‘High Risk’. An AUA Score of approximately 5 or 6 reflects “High Risk”

3 As per Rehabilitative Care Alliance definition of Restorative Potential

4 As per Rehabilitative Care Alliance Definitions Framework
Deliverables

The objective of the ‘Provincial Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED’ is to support timely access to bedded levels of rehabilitative care directly from the community for the target population i.e., high risk community-dwelling adults:

• who have restorative potential
• who have experienced potentially reversible functional loss/decline
• for whom home-and/or ambulatory-based rehabilitative care is either not a safe, effective or available option, and
• who are at risk of institutionalization (Acute Care or LTC) if nothing is done.
Deliverables

2. Development of a ‘Priority Process Toolkit’ to support operationalization of the provincial priority process including:

- A description of the Target Population
- A definition of Restorative Potential (developed in collaboration with the Definitions Task & Advisory Groups)
- A Checklist to Rule Out an Acute Cause of Functional Decline
- A Priority Process Referral Map
- Proposed Process Timelines
- A Priority Process Decision Tree
Deliverables

3. Endorsement of the Assessment Urgency Algorithm (AUA) as the standardized provincial screening tool to support early identification of at risk/high-risk older and/or medically complex adults.

4. Identification of the Provincial Referral Standard (PRS) for Rehab/CCC as the provincial standard referral form to be used to support direct admissions to bedded levels of rehabilitative care from the community/ED.
Deliverables

5. Identification of process and outcome indicators to support evaluation of the effectiveness of the ‘Provincial Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED’.

Approach to develop the “Priority Process’

- The Priority Process is intended to remove Acute Care as the sole point of access to rehabilitative care beds. The priority process is not intended to replace community-based options that are available to support achievement of the client’s/patient’s functional goals. In fact, the Task Group emphatically recommends that all community-based options be considered prior to considering referral to a bedded level of rehabilitative care.
Approach to develop the "Priority Process"

- The FS/MC Task Group developed the Priority Process to support provincial standardization of direct admission to bedded levels of rehabilitative care for the target population while acknowledging the need for local contextualization based on existing resources, structures etc. It is intended that each LHIN, when implementing the provincial standard, will identify clear local pathways, processes and lead providers that best position the local providers and resources to support operationalization of the ‘Priority Process’ within the proposed timelines.
Approach to develop the ‘Compendium’

• The Compendium is a collection of rehabilitative care-specific best and leading practices derived from a selection of existing gold standard references.

• It is organized in chapters corresponding to sectors of the rehabilitative care system enabling providers working within a specific sector of the system to easily review best practice information related to the rehabilitative care management of geriatric syndromes specific to their sector. Within each chapter, the content is organized by geriatric syndromes that may contribute to frailty.
Approach to develop the ‘Compendium’

- It is anticipated that use of the Compendium will begin to increase the ability of rehabilitative care practitioners to support completion of more comprehensive assessment and treatment of frail patients with geriatric syndromes that may be contributing to the presenting functional issues.
Stakeholder engagement

• The development of the FS/MC deliverables was informed by an extensive review of the literature and consultations with rehabilitative care providers across Canada including rehabilitation programs/centres in Canada and elsewhere and by the amalgamation of contributions of the diverse perspectives and geriatric expertise of the members of the FS/MC Task and Advisory Groups from across the province.
Stakeholder engagement

• Extensive provincial stakeholder consultation was completed throughout the development of the ‘Priority Process’ including with the MOHLTC to ensure alignment between the priority process and the Assess and Restore Guideline.

• As a result, the ‘Priority Process’ represents a provincial standard that supports provincial health system directions related to care of frail seniors and considers the immense variability in structures and resources currently in place across the province.
Implementation considerations

i. There is significant diversity in availability and types of geriatric and rehabilitative care resources (access to geriatricians, geriatric rehabilitative care beds and community based rehabilitative care) across the province as well as structures and processes to support centralized coordination of referrals to rehabilitative care beds.
Implementation considerations

ii. The gold standard for assessment of a ‘high risk’ patient to be a Comprehensive Geriatric Assessment (CGA), intervention and treatment by an interdisciplinary Specialized Geriatric Services team. However, if not available, Step#2 of the priority process should be a comprehensive clinical assessment completed by the local resource with the most specialized geriatric expertise.
Implementation considerations

iii. Successful implementation of the ‘Priority Process’ will require timely access to rehabilitative care beds for community referrals. While the Task Group has proposed timelines for this process based on subject-matter expert opinion/direction, it has suggested that until the Priority Process is piloted, decisions related to prioritization of community versus acute referrals are best made at the local level.
Implementation considerations

iv. A concern with admitting patients directly from the community is that they will not have had a recently completed comprehensive acute care work-up and may be admitted to a facility that lacks intensive medical resources. To mitigate this risk, the FS/MC Task Group developed the ‘Checklist to Rule Out an Acute Cause of Functional Decline’ to support due diligence on the part of referring providers and boost confidence amongst receiving providers that patients being referred to rehabilitative care beds from the community are medically appropriate.
Implementation considerations

v. Another concern with admitting high risk, frail adults directly from the community, is related to their risk of potentially needing institutionalization/Long Term Care (LTC). The Task Group suggests that in order to reduce this concern, that local processes be developed to support those who do end up requiring LTC to wait in the community with intensive CCAC services (e.g., Home First) rather than in a rehabilitative care bed.
Implementation considerations

vi. The Task Group was challenged by limited data and evidence to guide the development of the Proposed Process Timelines. As such, the proposed timelines are a standard to strive towards and are expected to be informed by pilots of the Priority Process.

vii. While the AUA is effective and appropriate for screening for the target population, utilization of the tool in Primary Care may be challenged by the volume of screening tools currently being presented to this group. Therefore, efforts to integrate the AUA into Electronic Medical Record (EMR) platforms may enable the use of the AUA amongst Primary Care providers.
Implementation considerations

viii. While the Compendium provides an opportunity for rehabilitative care providers to review relevant, existing best practices related to the assessment and treatment of geriatric syndromes, review of the Compendium alone will not translate into practice changes. Realization of the full benefit of the ‘Compendium’ will require organizations and health service providers to identify and implement deliberate structures, processes and opportunities for rehabilitative care providers to translate the best practices in the ‘Compendium’ into new knowledge, skill and practice patterns.
Next steps

• For LHINs to fully and successfully operationalize a regional Assess and Restore philosophy, the full continuum of resources needs to be developed. Specifically, timely access to rehabilitative care beds, outpatient and other community-based rehabilitative care services as well as in-home rehabilitative care and support services are required. Development of this philosophy is being advanced by the MOHLTC’s Assess and Restore 2014/15-2016/17 funding.

• Throughout its 2nd mandate, the RCA will continue to support LHINs in the implementation of Assess and Restore funded initiatives and in cross-LHIN coordination of Assess and Restore project objectives and learnings.
Next steps

• Utilization of the ‘Compendium of Rehabilitative Care Best Practices to Support the Assessment and Treatment of the Geriatric Syndromes’ will support the development of competency within the rehabilitative care system to identify and manage geriatric syndromes.

• Use of the Compendium will support rehabilitative care practitioners (i.e., health care providers who are working with patients with functional goals) to contribute to the health system’s need to distribute knowledge and skills related to frailty and geriatric syndromes so that practitioners with specialized geriatric expertise can be reserved for the patients with the greatest and most complex geriatric needs.
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Redefining the delivery of rehabilitative care

“Rehabilitative Care” is a broad range of interventions that result in the improved physical, mental and social well-being of those suffering from injury, illness or chronic disease. The Rehabilitative Care Alliance, an Ontario-wide collaborative, is working together with stakeholders to standardize rehabilitative
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