Step #1 Early Identification/ Screening

Where	Community			ED
Who	H&CC	CSS	Primary Care	GEMS or Delegate
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	• Upon presentation with functional impairment(s)
How	**Assessment Urgency Algorithm (AUA)/CLINICAL IMPRESSION**			

- If the screen identifies the patient as being 'high risk'[ii], an urgent comprehensive assessment may be required if clinically appropriate and/or not recently completed.
- The assessment in Step #2 is to be completed collaboratively with Primary Care, SGS[i] & 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

Who	H&CC	Specialized Geriatric Services[i]	Primary Care Provider(s)
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"[ii] ✓ Recent ADL/functional decline ✓ Risk of needing ED, hospital or LTC if nothing is done B. Confirmation of Restorative Potential[iii] 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

Lead Provider*	Centralized Intake	Receiving Bedded Rehabilitative Care Provider
What	A. Confirm patient is eligible for bedded level of Rehabilitative Care[iv] B. Determine most appropriate level of bedded Rehabilitative Care[iv] **NOTE**: Expedited "priority" access may be considered for patients who present to ED or are anticipated to imminently require institutionalization	

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

[i] As per definition provided in "Specialized Geriatric Services - Review Template" (July 7, 2014). Ministry of Health and Long-Term Care (MOHLTC)

[ii] As per Rehabilitative Care Alliance definition of 'High Risk'. An AUA Score of approximately 5 or 6 reflects "High Risk"

[iii] As per Rehabilitative Care Alliance definition of Restorative Potential

[iv] As per Rehabilitative Care Alliance Definitions Framework