Alberta Health Services
Geriatric Grand Rounds

Ontario's Rehabilitative Care Alliance - Addressing the Needs of the Complex Frail Elderly
Presentation Objectives

1. Describe the Development/Structure of the Rehabilitative Care Alliance

2. Describe two key deliverables of the RCA’s first mandate:
   - A Standardized Provincial ‘Priority Process’ to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community
   - A Compendium of Rehabilitative Care Best Practices to Support the Assessment and Treatment of the Geriatric Syndromes.

       .......as part of both a provincial Rehabilitative Care System as well as an Assess & Restore philosophy.

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Meeting Objective #1

Describe the Development/Structure of the Rehabilitative Care Alliance
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.”

First Mandate Deliverables

- LHIN CEOs established the Rehabilitative Care Alliance (RCA) in April 2013 for a two-year mandate.

- Leadership of the RCA Secretariat brought together representatives from all LHINs, MOHLTC, HSPs from hospital and community sectors, patients and caregivers.

- Full & summary reports provide an overview of the recommendations developed for LHINs and HSPs based on the RCA’s five priority areas of focus.
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.
A proposed second mandate work plan was submitted to and approved/endorsed by the LHIN CEOs on February 19, 2015.

This approval/endorsement positions the RCA’s first mandate deliverables for full provincial implementation by LHINs by March 2017.

The RCA will play a coordinating/supporting role as LHINs implement the deliverables.
**Mandate II Governance**

**LHIN CEOs**

Rehabilitative Care Alliance Steering Committee

Co-Chairs – Donna Cripps and Peter Nord

**GTA Rehab Network Secretariat**

Accountable to LHIN CEOs through Alliance Co-Chairs

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**ENABLERS**

**GTA Rehab Network Secretariat Support** (Communication, Stakeholder Engagement, Coordination/Administration, Decision Support etc.)

**Contextual/Influencing Initiatives**

(Assess & Restore, Health System Funding Reform, Integrated Funding Pilots, Coordinated Access, etc.)

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**QBP TJR Task & Advisory Groups**

Debra Carson, Trillium Health Partners

**QBP Hip Fracture Task & Advisory Groups**

Roy Butler, St. Joseph’s Health Care, London

**Definitions & CP Task & Advisory Groups**

Dale Clement, WW CCAC
Mark Edmonds, CW LHIN

**Outpatient / Ambulatory Task & Advisory Groups**

Marie Disotto-Monastero, Sunnybrook
Michael Gekas, Sinai Health System
Chris Sulway, TC LHIN

**FS/MC / A&R Task & Advisory Groups**

Dr. Jo-Anne Clarke, North East SGS
Carol Halt, NE LHIN

**System Eval Task & Advisory Groups**

Imtiaz Daniel, OHA
Michelle Collins, MH LHIN & Marilee Suter, CE LHIN

**LHIN & HSP Leads Advisory Group**

Mark Edmonds, CW LHIN & Andrea Lee, Health Sciences North

**Patient/Caregiver Advisory Group**

Charissa Levy, RCA Executive Director
Meeting Objective #2

Describe two key deliverables of the RCA’s first mandate....

△ A Standardized Provincial ‘Priority Process’ to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community

△ A Compendium of Rehabilitative Care Best Practices to Support the Assessment and Treatment of the Geriatric Syndromes.

......as part of both a provincial Rehabilitative Care System as well as an Assess & Restore philosophy.
Develop a rehabilitative care approach for Frail Senior/Medically Complex populations to support operationalization of priority elements of the “Essential Elements of Assess and Restore Framework” ¹

¹ 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)
Assess and Restore Framework to Support Aging in Place

1Living 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)

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Key Elements of an Assess and Restore Approach to Care

1. Screening of ‘at-risk’ seniors in community, primary care, and hospital settings
2. Assessment to determine whether a person is at high risk for loss of independence, has restorative potential, and requires facility-based care
3. Navigation & Placement to the appropriate provider, setting, and type of care
4. Facility-Based A&R interventions based on best practices in care delivery
5. Transitions home with linkages to primary care and other community supports

\(^1\text{Ministry of Health and Long Term Care, Assess and Restore Guideline. October 2014}\)
Deliverables Mandate of the Frail Senior/Medically Complex Task Group in Mandate I

- Standardized ‘Priority Process’ to facilitate direct admission of high risk adults* to bedded levels of rehabilitative care from the community or ED including screening, assessment and referral processes. Indicators to evaluate impact of the priority process.

- Compendium of evidence-based and leading rehabilitative care practices to support development of capability amongst rehabilitative care professionals across the continuum to effectively identify and manage geriatric syndromes.

*For those who have experienced potentially reversible functional loss/decline, have restorative potential, are at risk of institutionalization (acute care or LTC) if nothing is done, and for whom community options are not appropriate / available.
NOTE: The FS/MC Task group has developed this process to support provincial standardization while acknowledging the need for local contextualization based on existing resources, structures etc. It is intended that each LHIN will identify a “Lead Provider” that is best positioned locally to support the process within the proposed (draft) timelines.
NOTE: The FS/MC Task group has developed this process to support provincial standardization while acknowledging the need for local contextualization based on existing resources, structures etc. It is intended that each LHIN will identify a “Lead Provider” that is best positioned locally to support the process within the proposed (draft) timelines.
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<thead>
<tr>
<th>Step #1</th>
<th>Early Identification/Screening</th>
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<tbody>
<tr>
<td><strong>Where</strong></td>
<td><strong>Community</strong></td>
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<tr>
<td><strong>Who</strong></td>
<td>CCAC</td>
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</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 | • Upon presentation with functional impairment(s) |
| **How** | | | |

**Assessment Urgency Algorithm (AUA)/CLINICAL IMPRESSION**

- If the screen identifies the patient as being ‘high risk’\(\text{ii}\), 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 \(\text{i}\) & other involved community providers.

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<thead>
<tr>
<th>Step #2</th>
<th>Assessment to Determine Need for Bedded Rehabilitative Care</th>
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</table>
| **Who** | CCAC  
Specialized Geriatric Services \(\text{i}\)  
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” \(\text{ii}\)  
   - Recent ADL/functional decline  
   - Risk of needing ED, hospital or LTC if nothing is done  
B. Confirmation of Restorative Potential \(\text{iii}\)  
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.

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

\(\text{i}\) As per definition provided in “Specialized Geriatric Services - Review Template” (July 7, 2014). Ministry of Health and Long-Term Care (MOHLTC)

\(\text{ii}\) As per Rehabilitative Care Alliance definition of ‘High Risk’. An AUA Score of approximately 5 or 6 reflects “High Risk”

\(\text{iii}\) As per Rehabilitative Care Alliance Definition of Restorative Potential

\(\text{iv}\) As per Rehabilitative Care Alliance Definitions Framework
Direct Access Priority Process Tools

1. Description of Target Population
2. Assessment Urgency Algorithm (for stratified screening)
3. Definition of Restorative Potential
4. Checklist to Rule Out an Acute Cause of Functional Decline
5. Referral Form (Provincial Referral Standard for Rehab/CCC)
6. RCA FS/MC Priority Process Referral Map
7. RCA FS/MC Priority Process Timelines
8. RCA FS/MC Priority Process Decision Tree
9. RCA FS/MC Priority Process Indicators
10. RCA FS/MC Compendium
• Community-dwelling adult,
• with 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.

RCA Frail Senior/Medically Complex Task Group (2014)
Geriatric Case Finding in the Emergency Department – Opportunities and Challenges. Andrew P. Costa, PhD CIHR Fellow, Institute for Clinical Evaluative Sciences & Mount Sinai, Toronto, Ontario, Canada, Assistant Professor, (Part Time), Department of Medicine, McMaster University, Hamilton, Ontario, Canada

Assessment Urgency Algorithm
### AUA Score and Features

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Self-reliant in ADLs / IADLs</th>
<th>Health is excellent or good</th>
<th>No unstable health conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>Self-reliant in ADLs/IADLs</td>
<td>Health is fair or poor</td>
<td>No unstable health conditions</td>
</tr>
</tbody>
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### Focus of Interventions

- Enhance capacity for self management
- Prevention and sustaining tactics
- Social determinants
- Ensuring proper medical care
- Staying active
- Linking with primary care provider(s)

### Potential LHIN Specific Referral Options /Considerations

- Community Support Services
- Meals on Wheels
- Transportation Support
- Social Programs
- Senior Centres
- CCAC
- Physiotherapy
- Occupational therapy
- Social Work

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# Referral Pathway Summary

Adapted from: 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)

## AUA Score and Features

| Level 3 | Self-reliant in ADLs/IADLs  
Health is excellent or good OR fair or poor  
Has unstable health condition(s) |
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<td><strong>Focus of Interventions</strong></td>
<td><strong>Potential LHIN Specific Referral Options /Considerations</strong></td>
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</table>
| • Intervention and Management of Medical/Mental Health Complexities  
• Assess the Need for Services  
• Follow up with Primary Care Provider(s) | • CCAC  
• Geriatric Emergency Management  
• Memory clinic  
• Mental Health  
• Specialized Geriatric Services (SGS) / Mental health SGS  
• Geriatric Psychiatry  
• Follow up w Primary Care  
• Adult Day Program  
• Physiotherapy  
• Social work  
• Occupational therapy  
• Integrated Geriatric Services Worker (IGSW)  
• Community Day Programs (Meals on Wheels, Friendly Visitor)  
• Dietician  
• Community Pharmacist  
• Geriatrician or primary care has access to geriatrician for consults |
| • Work with primary care to build capacity to care for these persons to lessen the need for geriatrician consultation  
• Medication adherence/ polypharmacy  
• Enhance capacity for self management (If health reported “Excellent” of “Good”).  
• Refer to Geriatric Emergency Management or CCAC if health reported as “Poor” or “Fair”: | |

## Level 4
Unable to complete ADLs/IADLs  
Family reports not overwhelmed  
Reports mood as not sad, depressed, or hopeless  
No support required in hygiene ADLs
Referral Pathway Summary – HIGH RISK
Adapted from: 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)

<table>
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<tr>
<th>AUA Score and Features</th>
<th>Focus of Interventions</th>
<th>Potential LHIN Specific Referral Options /Considerations</th>
</tr>
</thead>
</table>
| **Level 5**            | • Intervention and Management of Medical/Mental Health Complexities  
                          • Wrapping care  
                          • Supportive discharge  
                          • Follow up with Family Doctor  
                          • More hands-on  
                          • Putting in referrals immediately  
                          • Immediate medical attention  
                          • Assessment of frailty/geriatric syndromes  
                          • Linking with family  
                          • Long Term Care discussion | • Geriatric Emergency Medicine  
                          • **Bedded Level of Rehabilitative Care**  
                          • CCAC  
                          • Geriatrician  
                          • Community day programs  
                          • Adult day program  
                          • Outreach programs  
                          • SGS programs (Mental health SGS)  
                          • Physiotherapy  
                          • Social Work  
                          • Clinical Pharmacist  
                          • Integrated Geriatric Services Worker (IGSW) |
| **Level 6**            | • Unable to complete ADLs or IADLs  
                          • Family reports not overwhelmed  
                          • Reports mood is sad, depressed, or hopeless  
                          • No support required in hygiene ADLs  
                          • OR  
                          • Unable to complete ADLs or IADLs  
                          • Family reports being overwhelmed |
Restorative Potential means that there is reason to believe (based on clinical assessment and expertise and evidence in the literature where available) that the patient's/client’s condition is likely to undergo functional improvement and benefit from rehabilitative care. The degree of restorative potential and benefit from the rehabilitative care should take into consideration the patient’s/client’s:

- Premorbid level of functioning
- Medical diagnosis/prognosis and co-morbidities (i.e., is there a maximum level of functioning that can be expected owing to the medical diagnosis /prognosis?)
- Ability to participate in and benefit from rehabilitative care within the context of the patient’s/client’s specific functional goals and direction of care needs.

Note: Determination of whether a patient/client has restorative potential includes consideration of all three of the above factors. Cognitive impairment, depression, delirium or discharge destination should not be used in isolation to influence a determination of restorative potential.

\(^1\)Rehabilitative Care Alliance Definitions Framework

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The following items have been suggested by rehabilitative care system stakeholders as being a set of relevant considerations to support communication between the referring practitioners (i.e. in ED or Primary Care) and receiving practitioners (i.e., those overseeing rehabilitative care beds) regarding the comprehensive medical assessment that has been completed to rule out an acute medical cause of functional decline amongst patients who are being admitted directly to a bedded level of rehabilitative care from the community.
Checklist to Rule Out and Acute Cause of Recent Functional Decline

- Consults and diagnostic tests for purposes of diagnosis or treatment of acute conditions have been completed and reported or pending test results are not anticipated to dramatically change the treatment plan.
- A clear diagnosis, co-morbidities / prognosis / goals of care have been established
- Vital signs are stable & treatment of acute conditions is complete
- Abnormal lab values have been acknowledged and addressed, as needed
- A follow-up plan is in place at the time of the referral
- Primary Care provider (where available) endorses a bedded level of rehabilitative care as the most appropriate setting to address the causes of the patient’s recent functional decline
- Date the patient last seen by Primary Care provider (where available)
- Date patient seen by specialist / geriatrics (& name of practitioner)
Provincial Referral Standard for Rehab/CCC
### ‘Referral Process for Direct Admissions from the Community’
#### Detailed Description of Step #3

<table>
<thead>
<tr>
<th>Direct Referral Receiving Bedded Rehabilitative Care Provider (s)</th>
<th>Referral to Centralized Intake</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Receiving Site Will:</strong></td>
<td><strong>Centralized Intake Will:</strong></td>
</tr>
<tr>
<td>Use the completed application form to validate eligibility for the indicated program AND determine the most appropriate level of bedded Rehabilitative Care</td>
<td>Forward the referral to all appropriate facilities that offer services that meet the patient’s needs</td>
</tr>
<tr>
<td><strong>Note:</strong> No additional re-assessment should be completed but rather a scan for completeness of the provided referral form and confirmation of eligibility for the program to which the patient is being referred.</td>
<td><strong>OR</strong> In cases where bed level matching is available, match the patient to the first available, appropriate bed within the system.</td>
</tr>
<tr>
<td>Communicate admission decision to Referrer</td>
<td>Act as the central point of communication for all facilities that receive the referral &amp; provide a coordinated response to the referring provider regarding the status of the request for admission to a rehabilitative care bed.</td>
</tr>
</tbody>
</table>

**Note 1:** Expedited “priority” access may be considered for patients who present to ED or who are anticipated to imminently require institutionalization.

**Note 2:** The ‘Lead Provider’ will monitor the patient’s status regularly while awaiting admission and communicate urgency for admission accordingly.
Proposed Process Timelines to Support Timely Access to a Bedded Level of Rehabilitative Care from the Community in Order to Avoid an Acute/ED Admission (To be Piloted)

- Expedited “priority” access may be considered for patients who present to ED or who are anticipated to imminently require institutionalization.
- The ‘Lead Provider’ will monitor the patient’s status regularly while awaiting admission and communicate urgency for admission accordingly.

**Within 8 Hours for Patients From the ED**

**Note 1:** This target is based on P4R targets and is most likely achievable in a scenario involving an internal transfer

**Note 2:** If admission to a rehabilitative care bed cannot be facilitated within 8 hours, arrange for intensive in-home services to support the patient at home while awaiting admission. If required community resources cannot be mobilized, acute care admission may be the most appropriate option

**Note 3:** Local targets should be adjusted to align with HSAAs, as appropriate.

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**Step #1**
Early Identification/Screening

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

**Step #3**
Referral

**Admission to a Bedded Level of Rehabilitative Care**

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**Within 2 Weeks for Patients From the Community**

If required, arrange for intensive in-home services to support the patient at home while awaiting admission

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During the RCA’s first mandate, the “Definitions” working group developed the “**RCA Decision Referral Tree**” to help guide decisions on the appropriate location for post-acute rehabilitation for all patient populations.

### Evaluative Questions to Measure Implementation and Impact on Outcomes

<table>
<thead>
<tr>
<th>Type of Indicator</th>
<th>Evaluative Question</th>
<th>Potential Indicator(s)</th>
</tr>
</thead>
</table>
| **Process Indicators** | Is the RCA’s ‘Priority Process’ being used to support the target population to access bedded levels of rehabilitative care? | • Proportion of direct admissions from community/ED to rehabilitative care beds  
• Average wait time for admission to rehabilitative care bed from ED/community  
• % of Acute ALC Designations to CCC & In-Patient Rehab within 2 Days of Admission to Acute Care (Acute Care Avoidance)*  
• Number of patients admitted to a bedded level of rehabilitative care from the community who are transferred to ED/Acute within 5 days of admission. |
| **Outcome Indicators** | Do patients who are directly admitted to bedded levels of rehabilitative care from the community have positive outcomes? | • % of patients directly admitted from the community that are discharged to home/baseline living environment*  
• Rate of acute care admissions within 30 days following discharge from a rehabilitative care bed (for patients directly admitted from the community/ED)  
• % of patients admitted into LTC within one-year following discharge from a bedded level of rehabilitative care (LTCH Admission Avoidance)* |

* Consistent with an Existing Indicator Within RCA Evaluation Framework
Direct Access Priority Process (DAPP) Expected Outcomes

Expected patient outcomes include:

▲ Achievement of at least baseline rates of discharges to previous living environment amongst patients directly admitted from the community (as compared to those admitted from acute care)

▲ Reduced rates of acute care re-admissions within 30 days following discharge from a rehabilitative care bed (for patients directly admitted from the community)
DAPP Expected Outcomes

Expected process outcomes include:

- An increase in the proportion of patients admitted to rehabilitative care beds from the community/Emergency Department
- Achievement of target admission wait time (TBD) to rehabilitative care bed from the ED/community
- A reduction in the number of patients designated ALC in acute care within 2 days of admission (Acute Care Avoidance)
- Increased rates of LTCH Admission Avoidance
Early Results Demonstrating the Impact of the DAPP

A pilot study was completed at Northumberland Hills Hospital (NHH) with 2013/14 ‘Assess & Restore’ funding where complex frail seniors with no acute medical issues were admitted directly from the ED to a rehabilitative care bed for a comprehensive assessment and treatment. 10 patients were included during the six week pilot study.

Outcomes during the pilot study period:

- 70% of admissions occurred directly from ED and avoided an acute care admission
- The target length of stay (33.75 days) was exceeded – the actual was 15.9 days. This translates to an average of 17.85 hospital days saved per person (based on average acute care and rehabilitative care length of stay LOS)
- The target FIM score change from admission to discharge (10 points) was also exceeded – the actual was 24.44 points
- 75% of those admitted had a discharge destination of home
Compendium of Evidence-based and Leading Practices to Support Assessment and Intervention of the ‘Geriatric Syndromes’
A summary of existing standardized tools, best- and leading clinical practices to support the assessment and treatment of each of the geriatric syndromes.

Specifically for use by rehabilitative care providers to bridge the knowledge to practice gap and to enhance capability within the system to manage frailty/geriatric syndromes.

Summarizes rehabilitative care-specific recommendations and best practices from industry-leading gold standard and enabling initiatives (e.g. Senior Friendly Hospital, RGP, RNAO etc.) into a single document to build capability within the rehabilitative care system to effectively & comprehensively address the functional goals of high-risk adults with restorative potential.
Table 1 – Compendium of existing standardized assessment tools, best and leading practices to support the assessment of each of the geriatric syndromes for use by rehabilitative care providers. These assessments will support development a comprehensive treatment plan, to address the functional goals of high-risk adults with restorative potential.

<table>
<thead>
<tr>
<th>Geriatric Syndromes and Other Considerations</th>
<th>Acute Care</th>
<th>Bedded Levels of Rehabilitative Care</th>
<th>Long Term Complex Medical Management/Long Term Care Homes</th>
<th>In-Home Rehabilitative Care</th>
<th>Outpatient/Ambulatory Rehabilitative Care</th>
<th>Community Based Rehabilitative Care</th>
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<td>Delirium</td>
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## Compendium - Standardized Interventions

**Table II** — Compendium of existing standardized intervention tools, best and leading practices to support the treatment of each of the geriatric syndromes for use by rehabilitative care providers. These assessments will support a comprehensive approach to treatment of high-risk adults with restorative potential.

<table>
<thead>
<tr>
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http://www.rehabcarealliance.ca/fsmc-compendium
Application – Case Studies
Case Study – Community to Rehabilitative Care Bed

- 75 year old female who has been followed since 2009 for depression, Parkinson's disease, rheumatoid arthritis, pain, functional decline.
- Housebound since 2009, coming out very rarely for doctor’s appointments.
- Very private and resistant to care, services, any home visits. Over the years, refused to have senior mental health involved, refused the arthritis society or their exercises. Has gradually come to accept our team.
- Our visits have focussed on getting her RA under control (had previously refused speciality care, we referred her to a specialist who was able to get her very active RA under control since 2011 with methotrexate, plaquenil). Her tremor predominant Parkinson’s has been reasonably controlled on sinemet 100/25 ½ TID (we had titrated up slightly in 2012-13, which resulted in mild diskinesias, and so had to come back down). Very depressed off and on – has seemed to improved with mirtazapine, albeit not completely.
- She lives with her son who had taken over many IADLs (secondary to pain and depression).
Case Study – Community to Rehabilitative Care Bed

**Home visit September 2013**

Patient continues to spend most of her days in bed. She is not interested in additional physiotherapy, or support with CCAC. Her son is providing her B12 and methotrexate injections weekly, as he has been trained to administer these.

Her pain “reasonably good today”. She did not have any pain in her hands and shoulders and was able to move reasonably well through the assessment, with the exception of significant pain at the right hip. She reports that she is now mobilizing with a walker and at times a 1-person assistance because of this pain. There have been no falls or cognitive changes.

She is independent with her commode at the bedside and also for mobilizing to the bathroom. She is independent with eating, but her son prepares her meals. She gets assistance with bathing and some assistance with dressing. She is independent with using the phone. She gets assistance with meal preparation, laundry and housekeeping, all due to limited mobility. She manages her own medications, which were at the bedside today, as well as finances.
Home visit June 2014

Patient bedbound, in tears. Discontinued her RA meds in December (thinks it was making her stomach symptoms worse). Many prescribed therapies and medications not on her list. Wishing she could die. Pain is worse that it has ever been. Refused her long acting narcotics. Very clear she wants help. Desperate to improve and be in less pain.

No longer leaves her bed. Son has not been working (had to take a leave of absence for 4 months). She has not mobilized independently since April. Has lost 10lbs since last assessment (no interest in eating), often vomiting. Tremor is worse, Parkinson’s worse, having a bowel movement q 7-11 days. Incontinence developing (urinary).

Son has to make a decision within the next 2 weeks as to whether he has to return to work.

**Meds** - Coversyl plus 5/2.5mg day, ASA, Percocet, Levodopa/Carbidopa ½ TAB TID, Mirtazapine 45mg OD, (She had stopped laxative, plaquenil, metyhotrexate, B12)

**Assessment** - Active RA (leading to pain), Active Parkinson’s (leading to worsening tremor, constipation, nausea), Constipation (leading to nausea, weight loss, urinary incontinence), Depression (secondary to pain and immobility, leading to medication non-compliance), Immobility, Deconditioning, Frailty, High Caregiver Burden. **AUA 6, CSHA 7**
Case Study – Community to Rehabilitative Care Bed

Needs re-institution of RA medications, optimization of pain, titration of PD meds (to 1 tab TID), treat constipation, physiotherapy, caregiver respite.
Needs urgent admission to rehab, or will be in LTC, hospital within days to weeks
All of the above has historically been treatable, and responded to therapy, mobility was independent less than 3 months ago, (therefore, restorative potential present).

Notes from Rehab June 2014:
Was very motivated to participate in rehab. Did seated morning exercise classes, stair training, worked with 2 WW.
Worked with OTA to become independent with ADLs at discharge.
Counselling with social work on not having her son doing all ADLs, IADLs. Used more information for MOW, private agencies.
Parkinson’s optimized (Increased sinemet to TID)
Constipation optimized (lax-a-day, improved PD treatment)
Medications switched to hydromorph contin 3mg BID with breakthrough 1mg PRN
Celebrex added
Re-referred to Rheumatology and Orthopedic program
Case Study – Community to Rehabilitative Care Bed

Home Visit September 2014
Upon my arrival she was sitting at the kitchen table eating soup with her son. She smiles and tells me she is doing much better. No longer bed bound, depressed. Pain under better control. She has continued to exercise (no small miracle). She has accepted CCAC services once weekly for personal care and some housekeeping services. Rheumatology involved, methotrexate restarted. Her son has returned to work after a lengthy caregiver leave.

Meds At Discharge:
Celebrex 200 mg daily
ASA 81 mg daily
Ferrous gluconate 300 BID
Hydromorphone contin CR 3mg BID
Hydromorphone 1mg PRN
Lax a Day once daily
Sinemet 100/25 TID
Mirtazapine 45 mg OD
Pantoprazole 40mg Daily

“The effect has been transformative”…
Help Us Keep You Informed

Consider signing up to receive our quarterly newsletter and other news from the Alliance, to keep updated on:

▲ Announcements of new resources and tools supporting best practice in rehabilitative care

▲ Opportunities to engage in and contribute to RCA projects and initiatives

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You can choose to unsubscribe at any time.
Thank you