RGPS of Ontario Education Day

Innovation in Care, Networks and Communities

Enabling Capacity in the Rehabilitative Care System to Support At Risk Adults:
Deliverables from the Rehabilitative Care Alliance’s (RCA’s) First Mandate
Presentation Objectives

Describe the development and utility of 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.
Mandate of the Frail Senior/Medically Complex Task Group in Mandate I

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)
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Key Elements of an Assess and Restore Approach to Care¹

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

¹Ministry 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.
<table>
<thead>
<tr>
<th>Step #1 Early Identification/Screening</th>
<th>Community</th>
<th>ED</th>
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</thead>
<tbody>
<tr>
<td>Who CCAC CSS Primary Care GEMS or Delegate</td>
<td>Referral for ADL/IADL support</td>
<td>• Upon presentation with functional impairment(s)</td>
</tr>
<tr>
<td>When • Referral for ADL/IADL support • A change in functional status • Part of 90 day re-Ax</td>
<td>• A change in functional status • At time of check-up</td>
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<tr>
<td>How</td>
<td>Assessment Urgency Algorithm (AUA)/CLINICAL IMPRESSION</td>
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- If the screen identifies the patient as being ‘high risk’, 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 & other involved community providers.

<table>
<thead>
<tr>
<th>Step #2 Assessment to Determine Need for Bedded Rehabilitative Care</th>
<th>CCAC</th>
<th>Specialized Geriatric Services</th>
<th>Primary Care Provider(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>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:</td>
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<td></td>
<td>A. Confirmation that Patient is “High Risk” ii</td>
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<td></td>
<td>✓ Recent ADL/functional decline</td>
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<td>✓ Risk of needing ED, hospital or LTC if nothing is done</td>
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<td>B. Confirmation of Restorative Potential iii</td>
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<td></td>
<td>C. Ruling Out an Acute Medical Cause of Functional Decline w Primary Care/ED Practitioner</td>
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What

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

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<thead>
<tr>
<th>Step #3 Streamlined Referral</th>
<th>Centralized Intake</th>
<th>Receiving Bedded Rehabilitative Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Provider*</td>
<td>A. Confirm patient is eligible for bedded level of Rehabilitative Care iv</td>
<td>B. Determine most appropriate level of bedded Rehabilitative Care iv</td>
</tr>
<tr>
<td>What</td>
<td>NOTE: Expedited “priority” access may be considered for patients who present to ED or are anticipated to imminently require institutionalization</td>
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</tbody>
</table>

* 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
FS/MC 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 Indicators
9. RCA FS/MC Priority Process Decision Tree
10. RCA FS/MC Compendium

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“High Risk” Target Population

- 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)
Assessment Urgency Algorithm

1. Self-reliance Indicator
   - Self-reliant
   - Impaired

2. Self-rated Health: Excellent or Good
   - No
   - Yes

3. Dyspnea OR Unstable Condition
   - No
   - Yes

4. Support in Personal Hygiene ADL
   - No
   - Yes

5. Family Overwhelmed
   - No
   - Yes

6. Self-rated Mood: Sad, Depressed, Hopeless
   - No
   - Yes

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.
http://interraiapp.uwaterloo.ca/users/sign_in
ID: test@test.ca
Password: testing123
# AUA 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)

<table>
<thead>
<tr>
<th>AUA Score and Features</th>
<th>Focus of Interventions</th>
<th>Potential LHIN Specific Referral Options /Considerations</th>
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</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
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<tr>
<td>Self-reliant in ADLs/IADLs</td>
<td>Enhance capacity for self management</td>
<td>Community Support Services</td>
</tr>
<tr>
<td>Health is excellent or good</td>
<td>Prevention and sustaining tactics</td>
<td>Meals on Wheels</td>
</tr>
<tr>
<td>No unstable health conditions</td>
<td>Social determinants</td>
<td>Transportation Support</td>
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<td></td>
<td>Ensuring proper medical care</td>
<td>Social Programs</td>
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<td></td>
<td>Staying active</td>
<td>Senior Centres</td>
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<td></td>
<td>Linking with primary care provider(s)</td>
<td>CCAC</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td>Enhance capacity for self management, no referral required UNLESS, concern expressed with ability to manage at home – then refer to Community Support Services</td>
<td>Physiotherapy</td>
</tr>
<tr>
<td>Self-reliant in ADLs/IADLs</td>
<td></td>
<td>Occupational therapy</td>
</tr>
<tr>
<td>Health is fair or poor</td>
<td></td>
<td>Social Work</td>
</tr>
<tr>
<td>No unstable health conditions</td>
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<td></td>
</tr>
</tbody>
</table>
## 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)

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</thead>
<tbody>
<tr>
<td><strong>Level 3</strong>&lt;br&gt;Self-reliant in ADLs/IADLs&lt;br&gt;Health is excellent or good OR fair or poor&lt;br&gt;Has unstable health condition(s)&lt;br&gt;</td>
<td>• Intervention and Management of Medical/Mental Health Complexities&lt;br&gt;• Assess the Need for Services&lt;br&gt;• Follow up with Primary Care Provider(s)&lt;br&gt;• Work with primary care to build capacity to care for these persons to lessen the need for geriatrician consultation&lt;br&gt;• Medication adherence/ poly-pharmacy&lt;br&gt;• Enhance capacity for self management (If health reported “Excellent” of “Good”).&lt;br&gt;• Refer to Geriatric Emergency Management or CCAC if health reported as “Poor” or “Fair”:</td>
<td>• CCAC&lt;br&gt;• Geriatric Emergency Management&lt;br&gt;• Memory clinic&lt;br&gt;• Mental Health&lt;br&gt;• Specialized Geriatric Services (SGS) / Mental health SGS&lt;br&gt;• Geriatric Psychiatry&lt;br&gt;• Follow up w Primary Care&lt;br&gt;• Adult Day Program&lt;br&gt;• Physiotherapy&lt;br&gt;• Social work&lt;br&gt;• Occupational therapy&lt;br&gt;• Integrated Geriatric Services Worker (IGSW)&lt;br&gt;• Community Day Programs (Meals on Wheels, Friendly Visitor)&lt;br&gt;• Dietician&lt;br&gt;• Community Pharmacist&lt;br&gt;• Geriatrician or primary care has access to geriatrician for consults</td>
</tr>
<tr>
<td><strong>Level 4</strong>&lt;br&gt;Unable to complete ADLs/IADLs&lt;br&gt;Family reports not overwhelmed&lt;br&gt;Reports mood as not sad, depressed, or hopeless&lt;br&gt;No support required in hygiene ADLs</td>
<td></td>
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</tbody>
</table>
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>
<thead>
<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**            | • Intervention and Management of Medical/Mental Health Complexities  
                         • Wrapping care  
                         • Supportive discharge  
                         • Follow up with Family Doctor |
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.

\(^{i}\) 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.
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)
Referral Form – Provincial Referral Standard for Rehab/CCC

https://www.ehealthontario.ca/portal/server.pt?open=512&objID=2895&PageID=0&cached=true&mode=2

www.rehabcarealliance.ca
Upon determination of the need for a bedded level of rehabilitative care (Step #2), complete referral form and send to most appropriate “Lead Provider” (as identified in collaboration w LHIN partners) who will lead/navigate Step #3.

**Direct Referral Receiving Bedded Rehabilitative Care Provider (s)**

The Receiving Site Will:

- Use the completed application form to validate eligibility for the indicated program AND determine the most appropriate level of bedded Rehabilitative Care

  **Note:** 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.

- Forward the referral to all appropriate facilities that offer services that meet the patient’s needs

  **OR**

- In cases where bed level matching is available, match the patient to the first available, appropriate bed within the system.

- Act as the central point of communication for all facilities that receive the referral & provide a coordinated response to the referring provider regarding the status of the request for admission to a rehabilitative care bed.

**Referral to Centralized Intake**

Centralized Intake Will:

- Communicate admission decision to Referrer

**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.

**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.
## 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
Priority Process Decision Tree

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.
Compendium - Standardized Assessment

Table I – 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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<tbody>
<tr>
<td>Delirium</td>
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<td>Cognitive impairment</td>
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<td>Depression</td>
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<td>Pain management</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>
<th>Geriatric Syndrome</th>
<th>Acute Care</th>
<th>Bedded Levels of Rehabilitative Care</th>
<th>Long Term Complex Medical Management/Long Term Care Homes</th>
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http://www.rehabcarealliance.ca/fsmc-compendium
Application – Case Studies