October 2014

Rehabilitative Care Alliance

Alliance Priority: Frail Senior/Medically Complex

Q&A

Process to Facilitate Direct Admissions to Rehabilitative Bedded Levels of Care from the Community/ED

Checklist to Rule Out an Acute Medical Cause of Recent Functional Decline

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The provincial Rehabilitative Care Alliance is developing recommendations for a standardized 'Process to Facilitate Direct Admissions to Rehabilitative Bedded Levels of Care from the Community/ED'. This process has been designed for community-dwelling adults 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.

The process includes 3 steps - screening, assessment and referral, as well as a number of supporting tools.

One tool is the "Checklist to Rule Out an Acute Medical Cause of Recent Functional Decline". The following Q&A has been prepared based on feedback the Alliance has received to date from physicians who have reviewed the checklist and process.

1. What is the purpose of the *checklist*?

To support consideration of medical issues that may warrant an acute care admission rather than admission to a rehabilitative care bed.

- Seeks to support the provincial priority to admit high risk patients with functional goals and restorative potential directly to rehabilitative care beds

(rather than having to access these beds via the emergency department or acute care)

- Intends to support the determination that patients who are being considered for admission to a rehabilitative care bed from the community can be managed safely from a medical perspective.
- Part of a larger process that includes other considerations to determine eligibility for a rehabilitative care bed.

2. Does use of the *checklist* mean Primary Care Physicians will be responsible for admitting their patients to rehabilitative care beds?

The Alliance is not proposing any changes to current MRP practices within rehabilitative care beds. Rather, the *checklist* is meant to support communication between the primary care practitioner and the receiving physician who oversees the rehabilitative care bed regarding the medical status of the patient.

3. I attempted to have a patient admitted directly to rehabilitative care from the community who had had a TKA, with a THA in the previous 6 months, was not gaining strength at home, and was suffering with major ongoing depression. My request was turned down because he was not 'appropriate'. The checklist doesn't help me decide if rehabilitation is appropriate.

The Alliance's *Process to Facilitate Direct Admissions to Rehabilitative Bedded Levels of Care from the Community/ED* is a provincial standard to support access to rehabilitative care beds from the community for high risk adults. The process is part of a larger collection of resources (including RCA's Definitions Frameworks for Rehabilitative Care) to enable the development of standardized eligibility and referral practices to support access to bedded levels of rehabilitative care from the community. All resources have been developed to allow for local customization as needed.

4. When I look at the *checklist*, it gives me the impression that these patients need to be admitted to an acute bed to identify the reason for their acute decline.

If a patient's medical issues are considered to be outside of what can safely be managed in a rehabilitative care bed, then an acute care admission may be required. The process is intended to reduce avoidable LTC and ED/acute care admissions (i.e. for those who are institutionalized due to potentially reversible functional rather than medical or non-reversible functional issues).

5. Where will I find the *checklist* when I need it?

Each LHIN will identify where and how to access the checklist.

6. The *checklist* doesn't mesh with my EMR. It appears to require filling out a form with information that we could easily generate from our EMRs. Given limits to how many hours there are in a day and the increasing number of complex forms we are being asked to complete, this extra work cuts into more important priorities (like patient care). The *checklist* doesn't ask anything that can't be addressed in an EMR generated letter.

Solutions that support integration of the *checklist* into EMRs would be ideal as part of the local *checklist* implementation. If the information can be generated directly from existing EMR letters, then this would support the objectives of the *checklist* - to support communication between the primary care practitioner and the receiving physician who oversees the rehabilitative care bed regarding the medical status of the patient, and to ensure the patient can be safely managed, from a medical perspective, in a rehabilitative care bed.

7. a) People who need rehabilitation have ongoing acute issues and abnormal test results that may require follow up. The *checklist* suggests the patient should not get rehabilitation, which contradicts the holistic definition of rehabilitation as presented, and b) The *checklist* has the potential to be a barrier to patients trying to access tightly-controlled beds - any missing detail, and the patient will be refused. While it creates more work for me, I don't see how it will help me or my patient.

The *checklist* is not intended to exclude patients who have active issues, but rather to identify those who have medical issues who are more appropriately managed in acute care. This is important feedback that will be considered by the Frail Senior/Medically Complex Task Group as it revises and refines the *checklist* to ensure this feedback is reflected.

8. Has the *checklist* been used with good results?

The *checklist* was recently developed by the Alliance's Frail Senior/Medically Complex Task Group. We will be taking all physician and nurse practitioner feedback into consideration at this stage in its development. Once it is in a final DRAFT form, it will be piloted/trialed with Primary Care Practitioners to ensure it achieves its purpose.

9. Where will these rehabilitative care beds come from that are accessible directly from the community? One would think patients occupying an acute hospital bed who are waiting for a rehabilitative care bed would take priority over people in the community.

Rehabilitative care beds accessed directly from the community would be part of existing resources. Decisions regarding local capacity to meet patient needs are within the scope of LHINs. The Frail Senior/Medically Complex Task Group may make high level suggestions/ recommendations regarding how referrals from the community should be prioritized relative to those from acute care, but priority setting decisions to support the right patients getting into the right beds at the right times are best made based on local needs and resources.

10. I thought the push was to do more for people in their own residences? Shouldn't this be a "rehabilitation hospital at home" sort of thing?

Part of the broader process to determine eligibility for a rehabilitative care bed from the community includes consideration of whether or not the patient's functional needs / goals can be addressed in the community (i.e. in home or outpatient / ambulatory). The goal is to have the functional needs of these high risk adults managed in the most clinically appropriate and cost efficient setting.

11. An inpatient rehabilitation bed would likely lose continuity of care with one's family doctor - someone else would be running the medical show on these complex patients. Also not likely good for holistic care.

Agreed, and if there are community based resources that can safely support the patient in their home, under the care of their primary care practitioner, then this would be ideal. However, if the patient's function is such that they cannot be safely managed at home (and they do not have acute medical issues requiring acute care admission) then admission to a bedded level of rehabilitative care would be appropriate.

12. I don't like that we are being put in the position of doing the screening for a program.

To clarify, the *checklist* is not intended to be used to screen for a program, but rather to support identification of patients who can safely be managed (from a medical perspective) in a rehabilitative care bed. The Assessment Urgency Algorithm (AUA) is a screening tool included in the *Process to Facilitate Direct Admissions to Rehabilitative Bedded Levels of Care from the Community/ED* and is intended to screen for risk of institutionalization (i.e. not for a rehabilitative care bed). The AUA stratifies patients according to six (6) risk levels that can be used to determine required services and resources based on relative risk. One of these services is a bedded level of rehabilitative care and is intended to be considered for those at the highest risk levels.