Rehabilitative Care Alliance

Updated July 2024

Expanded Direct Access Priority Process

Entry Points

- Remote Care Monitoring
- Outreach Teams
- Community Paramedicine
- Outpatient/ Community Clinic
- Home & Community Care Support Services
- Primary Care
- ED – Geriatric Emergency Management
- Other Community-based Health Service/Program

Determine Restorative Potential

Older adult 65+ presents with a change in baseline function
(2 weeks prior to illness/injury onset)

Framework = *RCA-PGLO Rehabilitative Care for Older Adults Living With/At Risk of Frailty: From Frailty to Resilience*

What has changed?
- ❑ ADLs/iADLs, Mobility, Cognition, Psychosocial
- ❑ Barthel Index
- ❑ Clinical Frailty Scale

How has it changed compared to…
- ❑ 6 weeks prior (Acute)
- ❑ 3 months prior (Sub-Acute)
- ❑ 4–12 month prior (Chronic/Gradual)
- ❑ 1 year or more prior (Chronic)

Why has it changed?
- ❑ Recent Acute Event
- ❑ Functional Decline

Is there an acute medical cause for functional decline?
- Y → Have acute medical concerns been addressed?
  - N → Address acute medical concerns
    Continue to reassess medical stability for potential future eligibility
  - Y → Does the person have restorative potential?
    - N → Refer to Specialized Geriatric Services for Comprehensive Geriatric Assessment
      Referral to other services as applicable, e.g., palliative care
    - Y
- N → Does the person have restorative potential?
  - N → Refer to Specialized Geriatric Services for Comprehensive Geriatric Assessment
    Referral to other services as applicable, e.g., palliative care
  - Y

Determining Restorative Potential

Individuals are considered to have restorative potential if there is reason to believe that, relative to the person's baseline function, rehab care will provide benefits and lead to functional improvement or maintenance of function.

Cognitive impairment, delirium, depression, discharge destination or age should **NOT** be used in isolation to influence a determination of restorative potential.

Rehabilitative care with a restorative approach should be the default.

The older adult and their care partner/s must be included in the circle of care.

See Framework Processes of Care: Determine Restorative Potential.

Assessment and Intervention

Not frail eg. CFS 1-3 Independent e.g. Barthel 80-100 Not medically complex	Mild frailty, eg. CFS 4-5 Minimally Dependent e.g. Barthel 60-79 Reasonably mobile	Mild to moderate frailty, eg. CFS 5-6 Partially Dependent e.g. Barthel 40-59 Medically/ psychosocially complex Care needs can be met in the community	Moderate to severe frailty, eg. CFS 6-7 Partial to totally dependent e.g. Barthel <59 Requires nursing care and support over and above what can be provided in the local community setting, i.e., no other reasonable means of rehabilitative care
Community-Based Prevention	**Outpatient Community Clinic/ In Home Care**	**Specialized Geriatric Services**	**Direct Access to Inpatient Rehabilitative Care**
Referral to preventions programs such as fall prevention and exercise classes. **Implement AVOID Frailty Framework (Canadian Frailty Network)** **Publicly funded rehabilitative care service listing:** www.rehabcareontario.ca (Public & private options, as available)	**Referrals to rehab services to address ADL/iADL/Mobility/Cognition/ Psychosocial needs** Consider referrals to: Home & Community Care Support Services Rehabilitation Outpatient Community Clinics/Services (Public & private options, as available) **Publicly funded rehabilitative care service listing:** www.rehabcareontario.ca	Referral to Specialized Geriatric Services **Publicly funded rehabilitative care service listing:** www.rehabcareontario.ca *	Referral to Inpatient Rehabilitative Care Align goal, functional trajectory, target population and functional characteristics to a program that has the resources to safely manage the medical needs. Refer to the RCA Framework for Bedded Levels of Rehabilitative Care

1. North East Specialized Geriatric Centre. Baseline Functional Status.
2. K. Rockwood et al. (2005). A global clinical measure of fitness and frailty in elderly people. CMAJ. 173:489-495.

MONITORING & FOLLOW-UP IN PRIMARY CARE: Monitor progress against the care plan. Patient progress and reassessment results are communicated across care partners.