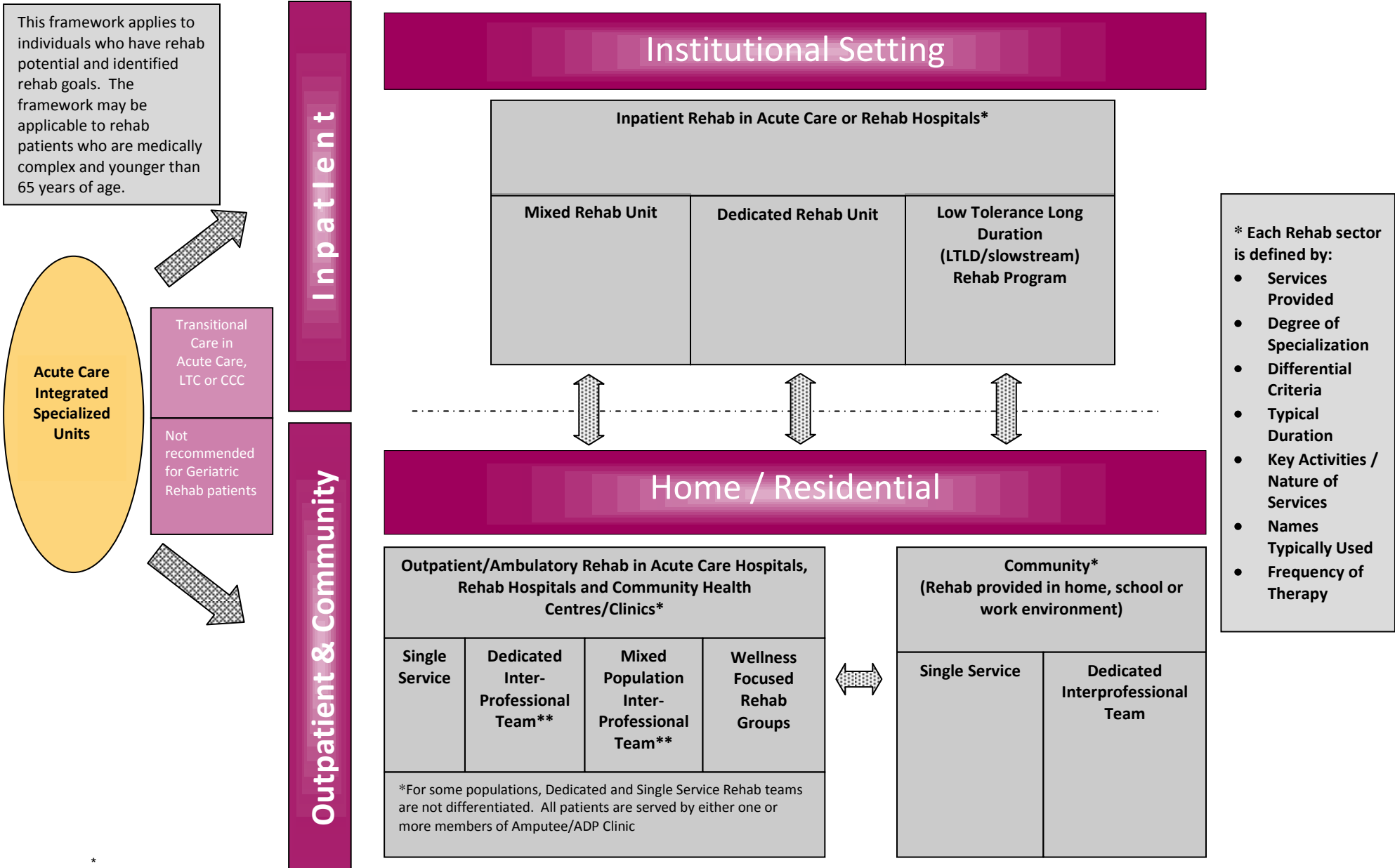


Geriatric Rehab Definition Framework



GUIDING PRINCIPLES

Objectives:

- I. Increase clarity and consistency in the forms of cognitive and physical rehab across the continuum by:**
 1. Clarifying the distinctions between and across institutional and community-based rehab programs.
 2. Classifying programs with consistent terminology.
 3. Describing the key features of institutional and community-based rehabilitation programs based on the services provided, the degree of specialization, differential/critical criteria, duration, and the primary focus of the rehab program/service.

- II. Inform planning and performance measurement through the development of standards for rehab program components against which rehab programs can be benchmarked.**

Guiding Principles:

1. The Rehab Definitions Conceptual Framework presupposes the World Health Organization's definition of "rehabilitation" as "*a progressive, dynamic, goal-oriented and often time-limited process, which enables an individual with an impairment to identify and reach his/her optimal mental, physical, cognitive and/or social functional level. Rehabilitation provides opportunities for the individual, the family and the community to accommodate a limitation or loss of function and aims to facilitate social integration and independence.*"

2. The Rehab Definitions Conceptual Framework is based on the assumption that clients participating in the programs described have rehab potential and rehab goals. For criteria regarding rehab potential, medical stability and rehab readiness for inpatient rehab, refer to the GTA Rehab Network's Inpatient Rehab Referral Guidelines in Appendix A. (A copy of the guidelines can also be downloaded from www.gtarehabnetwork.ca).

3. The Rehab Definitions Conceptual Framework refers to cognitive and physical forms of rehabilitation. The rehab conceptual diagram refers to acute care, inpatient rehab programs within institutional settings and outpatient and community-based rehab for clients residing at home or in a residential setting. The use of bi-directional arrows in the schematic reflects the flow of patients and continuity of care across these settings.

4. The framework identifies key features of rehab programs based on evidence-based practices where available (e.g. rehab beds are clustered together). In most instances these key features reflect current practices; however, some organizations may be required to implement changes within their organizations to achieve consistency with the criteria set out in the framework.
5. The term “patient” is used for individuals receiving rehabilitation in a hospital setting. The term “client” is used to refer to individuals receiving community rehab services.
6. The Rehab Definitions Conceptual Framework uses categories that have been defined based on the rehab needs of the patient and the typical services provided. Length of stay or the type of program/bed (i.e. designated rehab bed versus complex continuing care) in which the rehab is provided is not considered essential to defining rehab sectors.
7. The framework uses terminology that is consistent with the Ministry of Health and Long-Term Care (MOHTLC) guidelines for inpatient rehabilitation beds and can be applied to community and ambulatory service delivery.
8. While it is appreciated that much of rehabilitation occurs in third-party payer assessment centres or private clinics, the framework refers to publicly-funded rehabilitation. However, it is hoped that the framework will promote consistency in standards of care and equitable access across all rehab programs.
9. Input from healthcare providers representing acute care, regional rehab centres and community-based organizations that provide adult (including geriatric) and paediatric rehab has been obtained to validate the Rehab Definitions Conceptual Framework.
10. The Geriatric Rehab Definitions Framework will be reviewed every 2 – 3 years to incorporate any newly emerging research in geriatric rehab.

GLOSSARY OF REHAB COMPONENT TERMS

Dedicated Interprofessional Team (Community): Rehab provided in the home, school or work environment by an interdisciplinary team using a coordinated, integrated approach for specific rehab populations or to reduce the impact of a particular disability.

Dedicated Interprofessional Team (Outpatient/Ambulatory Rehab): Outpatient rehab provided by an interdisciplinary team with expertise in the treatment and assessment of a particular patient population. Outpatient/Ambulatory dedicated interprofessional teams are located in acute care hospitals, rehab hospitals and community health centres/clinics. They provide rehab to patients who require more than one rehab service and a coordinated rehab approach.

Dedicated Rehab Unit: An inpatient rehab unit located in acute care and rehab hospitals that serves a single patient population group and provides intensive rehabilitation. Some units may specialize in more than one diagnosis in related populations (e.g. Cardio/Respiratory, Orthopaedic/Amputation, etc.). A dedicated rehab unit is suitable for individuals who require 24-hour hospital care and who are in need of an interdisciplinary rehab program using a coordinated rehab approach.

Low Tolerance Long Duration (LTLD/slowstream) Rehab: Located in acute care and rehab hospitals, LTLD rehab is suitable for individuals in need of an interdisciplinary rehab program who may also have a chronic/complex condition requiring 24-hour hospital care over an extended period of time and who are expected to benefit from a slower-paced rehab program for a longer duration than is offered in dedicated or mixed rehab units.

Mixed Population Interprofessional Team (Outpatient/Ambulatory Rehab): Outpatient rehab that is provided by an interdisciplinary team that typically assesses and treats patients from a variety of patient population groups. Outpatient/Ambulatory mixed population interprofessional teams are located in acute care hospitals, rehab hospitals and community health centres/clinics. They provide rehab to patients who require more than one rehab service and a coordinated rehab approach.

Mixed Rehab Unit: Formerly referred to as a General inpatient rehab unit, this type of unit is located in acute care and rehab hospitals, provide intensive rehabilitation and serves a variety of patient population groups. The mixed rehab unit is suitable for individuals who require 24-hour hospital care and are in need of an interdisciplinary rehab program using a coordinated approach.

Single Service (Community): Individual rehab services that are usually provided through Community Care Access Centres. Single rehab services are suitable for individuals who are in need of one or more rehabilitation services in single specialty area(s)/profession(s) provided in the home, school or work environment. Although clients may receive more than one service, a coordinated approach is not used as rehab providers typically work as individual providers. However, some communication with other health providers may occur on an as-needed basis.

Single Service (Outpatient/Ambulatory Rehab): An outpatient rehab service located in acute care hospitals, rehab hospitals and community health centres/clinics that is suitable for individuals who are in need of an outpatient rehabilitation service in a single specialty area/profession. Clients may receive more than one rehab services; however, the services are not provided by way of a coordinated rehab approach. Services may include assessment only or assessment and treatment. Services may be provided during a one-time visit or multiple visits.

Wellness Focused Rehab Groups: These groups are provided in an outpatient/ambulatory setting and are led by an individual rehab provider or team or rehab specialists to enhance an individual's ability to cope with a particular disability or impairment. These time-limited groups are publicly-funded although a small fee may be charged for materials.

Geriatric Rehab Definition Framework*

ACUTE CARE	
Geriatric Assessment Unit	
Names Typically Used	<ul style="list-style-type: none"> • Geriatric Assessment Unit (GAU) or Acute Geriatric Assessment Unit (AGU)
Services Provided	<ul style="list-style-type: none"> • Services are provided by a dedicated interdisciplinary team with expertise in the principles of geriatric care. • Core team typically includes the following disciplines: Medical, Nursing, Physiotherapy, Occupational Therapy, Speech Language Pathology, Clinical Dietician, Social Work, Pharmacy, Chaplaincy/Pastoral Care • Psychogeriatric assessment is available on consultation. • The interdisciplinary team, including the physician, has expertise in the care of the elderly and familiar with the comprehensive geriatric approach. • Patients receive a Comprehensive Geriatric Assessment (CGA): a multidimensional diagnostic process to determine a frail older person's medical, psychosocial and functional capacities and limitations. The purpose of the assessment is to identify the reversible problems amenable to treatment and the remedial problems to be addressed through rehabilitation. A coordinated and integrated plan for treatment and follow-up is then developed. (See Appendix C)
Specialization vs. Non-Specialization	<ul style="list-style-type: none"> • The interdisciplinary team has knowledge and experience in assessing and treating patients with multiple co-morbidities, geriatric syndromes and disabilities.
Differential Criteria	<ul style="list-style-type: none"> • For older persons who are typically frail with complex medical, psychological and social problems. • GAU/AGUs require onsite access to diagnostics in order to support their assessments.
Typical Duration	<ul style="list-style-type: none"> • Length of stay target designated by the Regional Geriatric Program of Toronto is 2 weeks
Key Activities/Nature of Service	<ul style="list-style-type: none"> • Interdisciplinary assessment and short-term rehabilitation for older persons with complex medical, psychological and social problems. • Emphasis is on medical management; rehab goals are usually short-term.

TRANSITIONAL CARE

in Acute Care, CCC or LTC (for patients who will be discharged to home or residential care in LTC or CCC)

NOT APPROPRIATE FOR GERIATRIC PATIENTS WHO HAVE IDENTIFIABLE REHAB GOALS REQUIRING INPATIENT REHABILITATION.

Geriatric Rehab Definition Framework*

INPATIENT GERIATRIC REHAB			
Geriatric Rehabilitation			
A program designed to optimize the functioning of the elderly and often pre-morbidly frail individual who has experienced a loss of independence due to acute illness or injury. This is often superimposed on chronic functional and medical problems. ¹ Geriatric rehabilitation provides evaluative, diagnostic and therapeutic interventions to restore functional ability or enhance residual functional capacity in elderly people with disabling impairments. ²			
Geriatric Rehab on Mixed Rehab Units in Acute Care and Rehab Hospitals		Dedicated Geriatric Rehab Units in Acute Care and Rehab Hospital	Low Tolerance Long Duration (LTLD/slowstream) Geriatric Rehab
Suitable for individuals in need of an interdisciplinary rehab team/service who also require 24-hour hospital care.		Suitable for individuals in need of an interdisciplinary rehab team/service and who also require 24-hour hospital care.	Suitable for individuals in need of an interdisciplinary rehab team/service who may also have a chronic/complex condition requiring 24-hour hospital care over an extended period of time and who are expected to benefit from low intensity, long duration rehab.
Names Typically Used	<ul style="list-style-type: none"> • General Rehabilitation or Medical Rehabilitation 	<ul style="list-style-type: none"> • Geriatric Rehab • Geriatric Rehab Unit (GRU) • Geriatric Assessment & Rehab Unit (GARU)/Geriatric Assessment & Treatment Unit (GATU) 	<ul style="list-style-type: none"> • Geriatric Activation Program; Functional Enhancement
Services Provided	<ul style="list-style-type: none"> • Intensive rehab program. • Expectation that patients are able to tolerate a minimum of 120 minutes of therapeutic activity per day for 5-7 days per week. Therapeutic activity includes professional therapy (e.g. Occupational Therapy, Physiotherapy, OTA/PTA services under the guidance of an OT/PT and/or Speech Language Therapy) and nursing activities. 	<ul style="list-style-type: none"> • The pre-existing frailty and/or multiple needs of older patients may necessitate a lengthier and more complex rehab process than on a mixed unit. • The key differentiating feature of geriatric rehab is that the assessment and treatment of geriatric syndromes and multi-dimensional factors are as much a part of the rehab focus as is the illness or injury which directly led to the most recent hospitalization. On geriatric rehab units, the emphasis is on restoration of functional status.³ • These programs provide a moderately intensive rehab program. • It is expected that geriatric rehab patients can tolerate a minimum of 60 minutes of therapeutic activity, although on average, 120 minutes of therapy per patient 5 -7 days per week is offered. Therapeutic 	<ul style="list-style-type: none"> • Low to moderately intensive rehab program • Expectation is that patients can tolerate a minimum of 20 minutes of therapeutic activity per day. Average amount of therapy provided per patient is on average 30 minutes, 2 sessions per day, 3x per week as tolerated by the patient. Therapeutic activity includes professional therapy (e.g. Occupational Therapy, Physiotherapy, OTA/PTA services under the guidance of an OT/PT and/or Speech Language Therapy) and nursing activities. • An interdisciplinary team provides rehab. • Core team typically includes: Physician, Nursing, Physiotherapy, Occupational Therapy, Social Work, Pharmacy Consultation, Speech-Language Pathology,

¹ OHA Rehabilitation Working Group. Rehabilitation program definitions. March 1999 (Clinical Committees Survey Report: Current Status of Rehabilitation in the GTA).

² Wells JL, Seabrook JA, Stolee P, Borrie MJ, Knoefel F. State of the art in geriatric rehabilitation. Part 1. Review of frailty and comprehensive geriatric assessment, *Arch Phys Med Rehabil* 2003;84:890-7.

³ Borrie MJ, Stolee P, Knoefel F et al. Current best practices in geriatric rehabilitation in Canada. *Geriatr Today: Can J Geriatr Med Psychiatry* 2005; 8:148-153.

Geriatric Rehab Definition Framework*

INPATIENT GERIATRIC REHAB		
Geriatric Rehabilitation		
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Geriatric Rehab on Mixed Rehab Units in Acute Care and Rehab Hospitals	Dedicated Geriatric Rehab Units in Acute Care and Rehab Hospital	Low Tolerance Long Duration (LTLT/slowstream) Geriatric Rehab
<ul style="list-style-type: none"> • An interdisciplinary team provides rehab. Core team typically includes: Physician, Nursing, Physiotherapy, Occupational Therapy, Social Work, Pharmacy, Speech-Language Pathology, Clinical Dietician, Therapeutic Recreation and Chaplaincy/Pastoral Care. • Access to physician with expertise in medical complexities and familiarity with the principles of geriatric care (e.g. polypharmacy, incontinence, falls etc.) is available. • A critical mass of 8 beds within the unit is required to develop/maintain clinical expertise and the acquisition of special equipment/resources required to treat geriatric patients. 	<p>activity includes professional therapy (e.g. Occupational Therapy, Physiotherapy, OTA/PTA services under the guidance of an OT/PT and/or Speech Language Therapy) <i>and</i> nursing activities.</p> <ul style="list-style-type: none"> • Rehab services are provided by a dedicated interdisciplinary team. Team characteristics include expertise in geriatric assessment and treatment from medical, nursing and allied health perspectives, joint decision making and responsibility, negotiation of roles and tasks, and mutually defined goals. Core team typically includes: Physician, Nursing, Physiotherapy, Occupational Therapy, Social Work, Pharmacy, Speech-Language Pathology, Clinical Dietician, Therapeutic Recreation and Chaplaincy/Pastoral Care. • Geriatric and psycho-geriatric consultation should be available. • Program provides assessment and treatment of geriatric syndromes including: <ul style="list-style-type: none"> ○ Instability or falls ○ Isolation or depression ○ Cognitive impairment including delirium and dementia ○ Incontinence ○ Immobility ○ Poly-pharmacy ○ Inadequate nutrition. 	<p>Clinical Dietician, Therapeutic Recreation, Chaplaincy/Pastoral Care.</p> <ul style="list-style-type: none"> • Access to physician with expertise in medical complexities and familiarity with the principles of geriatric care (e.g. polypharmacy, incontinence, falls) is available. • A critical mass of 8 beds within the unit is required to develop/maintain clinical expertise and the acquisition of special equipment/resources required to treat geriatric patients.

Geriatric Rehab Definition Framework*

INPATIENT GERIATRIC REHAB			
Geriatric Rehabilitation			
A program designed to optimize the functioning of the elderly and often pre-morbidly frail individual who has experienced a loss of independence due to acute illness or injury. This is often superimposed on chronic functional and medical problems. ¹ Geriatric rehabilitation provides evaluative, diagnostic and therapeutic interventions to restore functional ability or enhance residual functional capacity in elderly people with disabling impairments. ²			
	Geriatric Rehab on Mixed Rehab Units in Acute Care and Rehab Hospitals	Dedicated Geriatric Rehab Units in Acute Care and Rehab Hospital	
	Low Tolerance Long Duration (LTLT/slowstream) Geriatric Rehab		
Specialization vs. Non-Specialization	<ul style="list-style-type: none"> • Rehab providers assess/ treat a variety of diagnostic/rehab population groups. • Specialization in multi system issues and familiarity with principles of geriatric care at least in medical staff is encouraged where there is a sufficient critical mass to support the development and maintenance of clinical expertise. 	<ul style="list-style-type: none"> • Program is staffed by a dedicated interdisciplinary team, including a physician who has expertise in the care of the elderly and is familiar with the comprehensive geriatric approach. • The interdisciplinary team should have knowledge and experience in assessing and treating patients with multiple co-morbidities, geriatric syndromes and disabilities. 	<ul style="list-style-type: none"> • Rehab providers assess/treat a variety of diagnostic/rehab population groups. • Specialization in multi system issues and familiarity with principles of geriatric care at least in medical staff is encouraged where there is a sufficient critical mass to support the development and maintenance of clinical expertise.
Differential Criteria	<ul style="list-style-type: none"> • Programs serve a variety of diagnostic population groups. • Geriatric patients who are appropriate for a mixed unit are patients: <ul style="list-style-type: none"> ○ Whose primary diagnosis or rehab needs falls outside of the other rehab population groupings (e.g. ABI, MSK, Stroke) ○ Whose premorbid functioning was no more than mildly impaired⁴ 	<ul style="list-style-type: none"> • Dedicated Geriatric rehab treats patients with: <ul style="list-style-type: none"> ○ Pre-existing frailty and/or ○ Complex underlying medical and functional problems, ○ Unexplained pre-morbid problems coping at home (e.g. Impaired pre-morbid function score⁵) ○ An insult or complicated course in hospital such as delirium or pneumonia and/or with current multi-system needs. ○ Moderate cognitive impairment ○ Reduced motivation secondary to depression • Team holds regular team meetings/conferences (at least one formal meeting per week) to co-ordinate care. • Beds are geographically clustered. 	<ul style="list-style-type: none"> • For patients who have experienced a complicated course in hospital or a recent multi-system illness requiring a longer period of rehabilitation of lower intensity than that offered in dedicated geriatric rehab programs or in mixed rehab programs to maximize rehab potential. • Program appropriate for patients whose pre-morbid functioning may have been impaired but whose primary rehab need is to address current multi-system needs through a slower-paced, longer duration rehab program. • The expectation is that patients will return to home or a community residential setting following LTLT rehab. • Dedicated interdisciplinary team, including access to a

⁴ See Premorbid Function Screen developed by the GTA Rehab Network in Appendix B.

⁵ See Premorbid Function Screen developed by the GTA Rehab Network in Appendix B

Geriatric Rehab Definition Framework*

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Geriatric Rehab on Mixed Rehab Units in Acute Care and Rehab Hospitals		Dedicated Geriatric Rehab Units in Acute Care and Rehab Hospital	Low Tolerance Long Duration (LTLD/slowstream) Geriatric Rehab
	<ul style="list-style-type: none"> ○ Who may have current multi-system needs ○ Who are able to tolerate a higher intensity rehab program (i.e. ≥ 120 minutes daily, 5 - 7 days per week) ● Coordinated team approach with at least one formal meeting per week to discuss patients' progress, goals and discharge plans. ● Geographically clustered beds/teams. ● Expectation is that patients will either be discharged home or to their preferred accommodation in the community or to a more specialized rehabilitation program. 	<ul style="list-style-type: none"> ● Expectation is that patients will either be discharged home or to their preferred accommodation in the community. ● Patients require a moderately paced rehab program for a longer duration than rehab programs for other diagnostic populations. ● Program provides a Comprehensive Geriatric Assessment (CGA): a multidimensional diagnostic process to determine a frail older person's medical, psychosocial and functional capacities and limitations. (See Appendix C) The purpose of the assessment is to identify the reversible problems amenable to treatment and the remedial problems to be addressed through rehabilitation. A coordinated and integrated plan for treatment and follow-up is then developed. ● Initial screening, monitoring and outcome evaluation is consistently recommended as a best practice. All patients involved in rehabilitation programmes need to be systematically evaluated at key stages using well-validated standardized measures which embody aspects of impairment, disability or dependency. Measures for geriatric populations referenced in the literature include the Mini Mental State Exam (MMSE)⁶ and Geriatric Depression Scale (GDS⁷). Nutritional screening is also a necessary component. 	<p>physician with specialization in the medical complexities found in geriatric patients.</p> <ul style="list-style-type: none"> ● Coordinated team approach with regular team meetings/conferences. ● Geographically clustered beds/teams ● Patients may be exempt from co-payment when located in CCC while the realistic goal for them remains returning to the community.
Typical Duration	<ul style="list-style-type: none"> ● 2-8 weeks 	<ul style="list-style-type: none"> ● Length of Stay (LOS) targets designated by the Regional Geriatric Program of Toronto are 4-6 weeks for GATUs and 4-12 weeks for GRUs. 	<ul style="list-style-type: none"> ● Typical duration is 3-6 months.
Key Activities/	<ul style="list-style-type: none"> ● Program provides intensive 	<ul style="list-style-type: none"> ● Geriatric rehabilitation programs are suitable for individuals requiring 	<ul style="list-style-type: none"> ● LTLD rehab is typically offered in complex continuing

⁶ Folstein MF, Folstein SE, McHugh PR. "Mini Mental State". A practical method for grading the cognitive state of patients for the clinician. *J. Psychiatri Res* 1975;12:189-98.

⁷ Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression scale: a preliminary report. *J. Psychiatric Res* 1982-1983;17:37-49.

Geriatric Rehab Definition Framework*

INPATIENT GERIATRIC REHAB			
Geriatric Rehabilitation			
A program designed to optimize the functioning of the elderly and often pre-morbidly frail individual who has experienced a loss of independence due to acute illness or injury. This is often superimposed on chronic functional and medical problems. ¹ Geriatric rehabilitation provides evaluative, diagnostic and therapeutic interventions to restore functional ability or enhance residual functional capacity in elderly people with disabling impairments. ²			
Geriatric Rehab on Mixed Rehab Units in Acute Care and Rehab Hospitals		Dedicated Geriatric Rehab Units in Acute Care and Rehab Hospital	Low Tolerance Long Duration (LTLD/slowstream) Geriatric Rehab
Nature of Service	<p>interdisciplinary rehab program for geriatric patients.</p> <ul style="list-style-type: none"> Wellness-focussed education that provides health education, goal setting, behaviour change principles and practices to promote health and wellbeing of the individual, including secondary prevention, are offered. 	<p>a moderately intensive interdisciplinary rehab program.</p> <ul style="list-style-type: none"> Wellness-focussed education that provides health education, goal setting, behaviour change principles and practices to promote health and wellbeing of the individual, including secondary prevention, are offered. The use of Goal Attainment Scaling (GAS)⁸ is frequently referred to as a measure of user and caregiver satisfaction and involvement. Goals need to be individual and meaningful to the patient/family. Improvement is measured in terms of enhanced ability in Activities of Daily Living/instrumental Activities of Daily Living (ADL/iADL) or improvement in quality of life. 	<p>care.</p> <ul style="list-style-type: none"> LTLD rehab is suitable for individuals in need of an interdisciplinary rehab program, who require an extended period of rehab to maximize recovery. Wellness-focussed education that provides health education, goal setting, behaviour change principles and practices to promote health and wellbeing of the individual, including secondary prevention, are offered.

⁸ Kiresuk TJ, Smith A, Cardillo JE, editors. Goal Attainment scaling: applications, theory and measurement. Hillsdale: Erlbaum: 1994.

Geriatric Rehab Definition Framework*

OUTPATIENT/AMBULATORY GERIATRIC REHAB PROGRAMS					
Single Service in Acute Care and Rehab Hospitals		Dedicated Interprofessional Geriatric Team in Acute Care and Rehab Hospitals		Mixed Population Interprofessional Team in Acute Care and Rehab Hospitals	Wellness Focused Rehab Groups
Suitable for individuals who are in need of an outpatient rehabilitation service in a single specialty area/profession. Services may include assessment only or assessment and treatment. Services may be provided during a one-time visit or multiple visits.		Suitable for geriatric rehab patients with complex/multiple comorbidities who have more than one rehab need and require an interdisciplinary rehab program and coordinated approach.		Suitable for geriatric rehab patients whose functioning is not severely compromised due to complex/multiple comorbidities and who have more than one rehab need requiring an interdisciplinary rehab program and coordinated approach.	Groups offered in an outpatient setting
Names Typically Used	<ul style="list-style-type: none"> • Usually Outpatient + profession (e.g., Outpatient Physiotherapy, Outpatient Occupational Therapy). • Outpatient specialty area (e.g. Seating Clinic, Gait Clinic Hearing Clinic, Swallowing Clinic) 	<ul style="list-style-type: none"> • Geriatric Day Hospital, Seniors Day Hospital 	<ul style="list-style-type: none"> • General Day Hospital or Day Treatment Program 	<ul style="list-style-type: none"> • Self-Management Groups, Living with [Chronic Disease] Groups 	
Services Provided	<ul style="list-style-type: none"> • Varies depending on specialty areas within institution. • Health professionals provide: <ol style="list-style-type: none"> a. A specialty service for a specific impairment or disability (e.g. gait, mobility, hearing) or b. General profession-specific assessment, treatment plan recommendations or implementation of treatment plan and/or referral to other service providers. <p>Note: Specialty service may use an interprofessional approach.</p>	<ul style="list-style-type: none"> • Patients are expected to tolerate a minimum of 30 - 45 minutes of therapy per session. • Care is provided by an interdisciplinary team with expertise in the care of the elderly including knowledge and experience in assessing and treating patients with multiple co-morbidities, geriatric syndromes and disabilities. • Core team typically includes one or more of the following: Physician, Nursing, Physiotherapy, Occupational Therapy and some programs may have access to Social Work, Pharmacy Consultation, Speech-Language Pathology, Clinical Dietician, and Therapeutic Recreation. Psychology may be available on consultation. 	<ul style="list-style-type: none"> • Patients are expected to tolerate a minimum of 45 - 60 minutes of therapy per session. • Care is provided by an interdisciplinary team. It is recommended that the team have an understanding in the care of the elderly, if such patients are seen, to address the needs of the frail elderly. • Core team typically includes one or more of the following: Physician, Nursing, Physiotherapy, Occupational Therapy and some programs may 	<ul style="list-style-type: none"> • Groups are led by an individual rehab provider or team of rehab specialists • Classes offered may include education and/or an exercise program or a combination of both 	

Geriatric Rehab Definition Framework*

OUTPATIENT/AMBULATORY GERIATRIC REHAB PROGRAMS						
Single Service in Acute Care and Rehab Hospitals		Dedicated Interprofessional Geriatric Team in Acute Care and Rehab Hospitals		Mixed Population Interprofessional Team in Acute Care and Rehab Hospitals	Wellness Focused Rehab Groups	
		<ul style="list-style-type: none"> Specialized focused assessment and/or treatment are provided to resolve functional and/or psychological issues and promote re-integration to normal living or to maximize functional level. 		have access to Social Work, Pharmacy Consultation Speech-Language Pathology, Clinical Dietician, and Therapeutic Recreation.		
Specialization vs. Non-Specialization		<ul style="list-style-type: none"> Some services serve a particular specialty area (e.g. Seating Clinic or Gait Clinic). Other services are profession specific which may or may not be specialized for particular interventions or diagnostic groups. Familiarity with the principles of geriatric care and multi-system issues is encouraged in the healthcare professionals providing care. 		<ul style="list-style-type: none"> The Outpatient Dedicated Geriatric Interprofessional Team has expertise in geriatric care to treat patients who are typically frail, have multiple co-morbidities and functional impairment with: <ul style="list-style-type: none"> Complex underlying medical and functional problems Unexplained pre-morbid problems coping at home An insult or complicated course in hospital such as delirium, pneumonia or a fracture. 	<ul style="list-style-type: none"> Non-specialized. Rehab providers assess/treat patients from a variety of diagnostic population groups. However, for programs that treat frail, elderly patients, it is recommended that rehab providers have expertise in the principles of geriatric care. 	<ul style="list-style-type: none"> Groups focus on enhancing an individual's ability to cope and live with a particular disability or impairment
Differential Criteria		<ul style="list-style-type: none"> Patients are residing in the community with a specific rehab need which may be an impairment, performance, activity or participation issue that requires assessment and/or treatment by a health professional; familiarity with the principles of geriatric care is recommended. Patients may not have required an inpatient rehab program or other outpatient rehab programs. Some patients may be discharged from an inpatient rehab program or from acute care and require ongoing rehab to achieve higher functional goals. Patients may be referred from acute care, 		<ul style="list-style-type: none"> Suitable for frail, elderly patients residing in the community or who have been recently discharged from hospital and require a moderately intensive interdisciplinary rehab program. Patients typically have complex, multiple co-morbid conditions. Dedicated interdisciplinary team, including physician, with specialization in geriatric rehab to treat patients with complex medical and functional problems. Co-ordinated services with regular team meetings/conferences. Typically, patients are community patients who are responsible for arranging their own transportation to and from their outpatient appointments. 	<ul style="list-style-type: none"> Suitable for patients residing in the community or who have been recently discharged from hospital. For elderly patients whose functioning may be impaired but not severely compromised due to the presence of multiple co-morbidities. Dedicated interdisciplinary team including physician. It is recommended that the staff have familiarity with care of the elderly if such patients are accepted. 	<ul style="list-style-type: none"> These groups are led by one or more professional rehab providers Groups are time-limited and goal-oriented to increase coping and living with an impairment or disability Groups are publicly funded through the healthcare system

Geriatric Rehab Definition Framework*

OUTPATIENT/AMBULATORY GERIATRIC REHAB PROGRAMS					
Single Service in Acute Care and Rehab Hospitals		Dedicated Interprofessional Geriatric Team in Acute Care and Rehab Hospitals		Mixed Population Interprofessional Team in Acute Care and Rehab Hospitals	Wellness Focused Rehab Groups
	<p>rehabilitation, or family physicians or other health professionals working in the community.</p> <ul style="list-style-type: none"> • In some hospitals, the service is only available for patients of that institution and their physicians. • Typically, these are community patients who are responsible for arranging their own transportation to and from their outpatient appointments. 			<ul style="list-style-type: none"> • Coordinated services with regular team meetings/conferences • Typically, these are community patients who are responsible for arranging their own transportation to and from their outpatient appointments. 	
Typical Duration	<ul style="list-style-type: none"> • Varies depending on the type of service/program. Specialty clinics may provide one or a few visits until the problem is resolved or managed. Other profession specific treatment programs may occur once or several times a week for 6 – 12 weeks or longer. 		<ul style="list-style-type: none"> • 6-12 weeks, 2 times per week 	<ul style="list-style-type: none"> • 6-12 weeks, 2 times per week 	<ul style="list-style-type: none"> • 8 – 16 weeks
Key Activities/ Nature of Service	<ul style="list-style-type: none"> • Specialized focussed assessment and/or treatment to resolve a functional or psychological issue and to promote re-integration to normal living or to maximize functional level. • These services/programs may be publicly funded or privately funded. 		<ul style="list-style-type: none"> • The rehab programs recognize the need for a socially-stimulating environment to achieve maximal benefits. • Program provides treatment of geriatric syndromes: instability or falls, isolation or depression, cognitive impairment including delirium and dementia, incontinence, immobility, poly-pharmacy and inadequate nutrition. • The use of Goal Attainment Scaling (GAS)⁹ is frequently referred to as a measure of user and caregiver satisfaction and involvement. Goals need to 	<ul style="list-style-type: none"> • Programs are time limited and goal directed. • The program could be delivered in a group format or on an individual basis. 	<ul style="list-style-type: none"> • Disease or population-specific wellness programs offer group participation in health education, goal setting, behaviour change principles and practices to promote

⁹ Kiresuk TJ, Smith A, Cardillo JE, editors. Goal Attainment scaling: applications, theory and measurement. Hillsdale: Erlbaum: 1994.

Geriatric Rehab Definition Framework*

OUTPATIENT/AMBULATORY GERIATRIC REHAB PROGRAMS			
Single Service in Acute Care and Rehab Hospitals	Dedicated Interprofessional Geriatric Team in Acute Care and Rehab Hospitals	Mixed Population Interprofessional Team in Acute Care and Rehab Hospitals	Wellness Focused Rehab Groups
	<p>be individual and meaningful to the patient/family.</p> <ul style="list-style-type: none"> • Improvement is measured in terms of enhanced ability in mobility, ADL/iADLs or improvement in quality of life. • Risk factors that have been identified for ADL/IADL disability indicate that treatment should focus on diet, physical activity, hip fracture prevention, diagnosis and treatment of depression and cognitive impairment, and management of multiple co-morbidities among others.¹⁰ • The program could be delivered in an individual/ group format. 		<p>health and wellbeing of the individual</p> <ul style="list-style-type: none"> • Secondary prevention may be offered.

¹⁰ Naglie G, Gill SS. A systematic review of risk factors for functional disability in older adults. TRI; Univ Health Network. University of Toronto, Toronto, ON and Queen's University, Kingston ON

Geriatric Rehab Definition Framework*

COMMUNITY	
Community – Single Service Rehab is provided to client in home or work environment. Outreach Geriatric Services, which provide assessment only, are not included in this framework.	
Names Typically Used	Community Care Access Centre (CCAC)
Services Provided	<ul style="list-style-type: none"> • May include OT, PT, SLP, SW, Nursing, Case Management and Physician services. • Clients may receive more than one service. • Rehab providers typically work as individual providers; however, communication with other health providers occurs on an as-needed basis • CCACs provide in-home rehab services through contracts with Provider Agencies and manage clients through a Case Management collaborative model.
Specialization vs. Non-Specialization	<ul style="list-style-type: none"> • Health professionals may have experience in a particular diagnostic group or area (e.g. MSK, paediatrics). • It is recommended that the health professionals involved with frail, elderly seniors have expertise in the area of geriatric care.
Differential Criteria	<ul style="list-style-type: none"> • Service is provided in the environment that is most appropriate (e.g. client is home-bound; services are focussed on community re-integration).
Typical Duration	<ul style="list-style-type: none"> • CCAC involvement is typically offered for 4 – 12 weeks
Key Activities/Nature of Service	<ul style="list-style-type: none"> • Assessment, treatment, discharge planning to community activities and/or disease or population-specific wellness programs that provide health education, goal setting, behaviour change principles and practices to promote the health and wellbeing of the individual and secondary prevention as appropriate.

APPENDIX A:

INPATIENT REHAB REFERRAL GUIDELINES -- CRITERIA FOR REHAB CANDIDACY, MEDICAL STABILITY AND REHAB READINESS

(Please see the complete Inpatient Rehab Referral Guidelines document (www.gtarehabnetwork.ca) for guidelines regarding Timing and Submission of Referrals and Response to Referrals)

Determining if a patient is a candidate for inpatient rehabilitation ...

- ✓ Patient demonstrates by documented progress the potential to return to premorbid/baseline functioning or to increase in functional level with participation in rehab program.
- ✓ There is reason to believe that, based on clinical expertise and evidence in the literature, the patient's condition is likely to benefit from the rehab program/service.
- ✓ Goals for rehabilitation have been established and are specific, measurable, realistic and timely.
- ✓ The patient or substitute decision-maker has consented to treatment in the program and demonstrates willingness and motivation to participate in rehab program. (Exception: patients with reduced motivation/initiation secondary to diagnosis e.g. brain injury, depression).

Determining Medical Stability ...

- ✓ A clear diagnosis and co-morbidities have been established.
- ✓ At the time of discharge from acute care, acute medical issues have been addressed; disease processes and/or impairments are not precluding participation in rehab program.
- ✓ Patient's vital signs are stable.
- ✓ No undetermined medical issues (e.g. excessive shortness of breath, falls, congestive heart failure).
- ✓ Medication needs have been determined.

Determining Rehab Readiness ...

- ✓ Patient meets the criteria of a rehab candidate and medical stability as defined in guideline above.
- ✓ All medical investigations have been completed **or** a follow-up plan is in place at time of referral and follow-up appointments made by time of discharge.
- ✓ Patient's special needs have been determined.
- ✓ Patient is able to meet the minimum tolerance level of rehab program as defined by the admission criteria of rehab program.
- ✓ There are no behavioural or active psychiatric issues limiting patient's ability to participate in rehab program.
- ✓ Treatment for other co-morbid illnesses/conditions does not interfere with patient's ability to participate in rehab (e.g. dialysis or active cancer treatment resulting in fatigue or frequent absences from unit during rehab treatment sessions).
- ✓ Patient's discharge options following rehab have been discussed.

APPENDIX B: PREMORBID FUNCTION SCREEN*

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <p>1. Nutrition
Has patient had unanticipated weight loss in the last year (i.e. clothes fit loosely or weight loss \geq 5% of body weight)?</p> | <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> |
| <p>2. General Health Status
Has patient had two or more admissions to hospital in the last year?</p> | <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> |
| <p>3. Medication use
Did patient use 5 or more prescription medications on a regular basis?</p> | <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> |
| <p>4. Functional Independence
Did patient need help with 3 or more of the following: meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications?</p> | <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> |
| <p>5. Continence
Did patient have a problem with losing control of his/her urine?</p> | <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> |
| <p>6. Mobility
Has patient had a fall in past year?</p> | <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> |

Score = Total # of Yes answers.

Rating key: Mild Pre-morbid Challenges (1-2); Moderate Pre-Morbid Challenges (3-4); Severe (5-6)

* Screening tool is derived from the Edmonton Frail Scale (EFS) (see below). The following items used in the EFS were not included: Cognition, Social Support, Mood and Functional Performance. However these areas are addressed in the Inpatient Rehab Referral Guidelines of the GTA Rehab Network. The rating key is not part of the published tool.

References:

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Tsuyuki R, Tahir A, Rockwood K. Validity and reliability of the Edmonton Frail Scale. doi:10.1093/aging/afl041. Published electronically 6 June 2006.

APPENDIX C:

*COMPONENTS OF COMPREHENSIVE GERIATRIC ASSESSMENT¹¹

Components	Elements
Medical assessment	<ul style="list-style-type: none"> Problem list Co-morbid conditions and disease severity Medication review Nutritional status
Assessment of functioning	<ul style="list-style-type: none"> Pre-morbid/baseline level of functioning in I/ADLs\ Basic activities of daily living Instrumental activities of daily living Activity / exercise status Gait and balance
Psychological assessment	<ul style="list-style-type: none"> Mental status (cognitive) testing Mood / depression testing
Social assessment	<ul style="list-style-type: none"> Informal support needs and assets Care resource eligibility / financial assessment
Environmental assessment	<ul style="list-style-type: none"> Home safety Transportation and tele-health

¹¹ Wieland W., Hirth V. Comprehensive geriatric assessment. *Cancer Control* 2003 Nov-Dec: 10(6): 454-62.