Rehab/CCC Education Session

October 11, 2012
Today’s Agenda

12:30 – 1:00     Lunch/networking

1:00 – 1:10      Welcome/Introduction (Charissa Levy)

1:10 – 2:30      Rehab/CCC Presentations

- Baycrest
- Bridgepoint Health
- Providence Healthcare
- Runnymede Healthcare Centre
- St. John’s Rehab Hospital
- Toronto Grace Health Centre
- Toronto Rehab
- West Park Healthcare Centre

2:30 – 3:00      Questions/Discussion
Rehab/CCC Programs and Bed Counts

- Data presented is based on results of an annual survey of Rehab/CCC beds conducted in April 2012.

- Some programs/bed numbers have changed or will be changing.

- Information is provided as a guide. Exact bed numbers to be confirmed with organizations.
## Designated Rehab Beds
### (High Tolerance Short Duration / HTSD)

<table>
<thead>
<tr>
<th>LHIN</th>
<th>Organization</th>
<th>April 2012 Funded beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>St. John’s</td>
<td>160</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Baycrest</td>
<td>32</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Bridgepoint Health</td>
<td>96</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Providence Healthcare</td>
<td>87</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Runnymede Healthcare Centre</td>
<td>0</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Toronto Rehab/UHN</td>
<td>212*</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>West Park Healthcare Centre</td>
<td>133</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>720</strong></td>
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</tbody>
</table>

### Rehab (HTSD):
- Intensive rehab program
- Across programs and across hospitals, generally, HTSD Rehab programs provide ~ 60-120 minutes of therapy per day, 5-7 days per week
- Expectation that patients’ tolerance will increase as they progress in the therapy program

*Of these 212 designated rehab beds, 5 ABI rehab beds are “slow stream”
Low Tolerance Long Duration Rehab (LTLD) Beds in Complex Continuing Care

<table>
<thead>
<tr>
<th>LHIN</th>
<th>Organization</th>
<th>April 2012 Funded beds</th>
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</thead>
<tbody>
<tr>
<td>Central</td>
<td>St. John’s</td>
<td>0</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Baycrest</td>
<td>30</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Bridgepoint Health</td>
<td>120</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Providence Healthcare</td>
<td>158</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Runnymede Healthcare Centre</td>
<td>12</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Toronto Rehab/UHN</td>
<td>38</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>West Park Healthcare Centre</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>384</strong></td>
</tr>
</tbody>
</table>

**LTLD Rehab:**
- Low to moderately intensive rehab program
- Across programs and across hospitals, generally, LTLD Rehab programs provide ~ 30-60 minutes of therapy per day, 3-5 days per week
- Expectation that patients’ tolerance will increase as they progress in the therapy program
Overview of LTLD Program Descriptions

- **Baycrest** (30 beds)
  - To meet the physical and cognitive rehabilitation needs of frail seniors

- **Bridgepoint Health** (120 beds)
  - 36 Medical Activation
  - 52 MSK Activation
  - 32 Neuro Activation

- **Providence Healthcare** (158 beds)
  - 56 Stroke/Neuro LTLD
  - 67 LTLD Geriatrics
  - 35 LTLD Ortho/Amp
Overview of LTLD Program Descriptions

• Runnymede Healthcare Centre (12 beds)
  » To assist individuals who have sustained significant illness or injury or who have chronic/complex conditions
  » The interprofessional team will provide low to moderate intensity rehab therapy.

• Toronto Rehab LTLD (38 beds)
  » Neuro-physical stream (e.g. stroke, ABI, SCI or other neurological conditions)
  » Functional enhancement stream (e.g. severe physical deconditioning due to illness, surgery or trauma)

• West Park Healthcare Centre (26 beds)
  » Geriatric Functional Enhancement program
A specialized program of care providing programs for medically complex patients whose condition requires a hospital stay, regular onsite physician care and assessment, and active care management by specialized staff.

Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System, OHA May 2006
In Ontario, the term “complex continuing care” (CCC) is used interchangeably with “chronic care”. Complex continuing care provides continuing, medically complex and specialized services to both young and old, sometimes over extended periods of time. CCC is provided in hospitals for people who have long-term illnesses or disabilities typically requiring skilled, technology-based care not available at home or in long-term care facilities. CCC provides patients with room, board and other necessities in addition to medical care.

Ontario Ministry of Health and Long-Term Care, Downloaded July 2012
Complex Continuing Care (CCC) Beds (excluding LTLD beds)

<table>
<thead>
<tr>
<th>LHIN</th>
<th>Organization</th>
<th>April 2012 Funded beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>St. John’s</td>
<td>0</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Baycrest</td>
<td>180</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Bridgepoint Health</td>
<td>223</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Providence Healthcare</td>
<td>35</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Runnymede Healthcare Centre</td>
<td>188 (121 open)</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>Toronto Rehab/UHN</td>
<td>170</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>West Park Healthcare Centre</td>
<td>132</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>928</td>
</tr>
</tbody>
</table>

**CCC:**

- Patients are “transitioned” home and/or to other appropriate levels of care along the care continuum wherever possible.
- CCC has evolved into being viewed as a “resource” rather than a final destination.

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1. Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of The Health Care Delivery System, OHA May 2006
Overview of CCC Programs
(excluding LTLD beds)

- **Baycrest (180)**
  - General CCC (102 beds)
  - Palliative (31 beds)
  - Sub Acute Transition (27 beds)
  - Behavioural/Neurology (20)

- **Providence Healthcare (35)**
  - Palliative (35 beds)

- **Runnymede Healthcare Centre**
  - 188 General CCC beds
    (121 open)

- **Bridgepoint Health (223)**
  - General CCC (10)
  - Palliative (33)
  - Dialysis (40)
  - Transitional Care (34)
  - Neuro Activation (20)
  - Neuro Muscular (50)
  - ALC Connect (36)
Overview of CCC Programs
(excluding LTLD beds)

- **Toronto Rehab (170)**
  - General (120 beds)
  - Palliative (10)
  - Dialysis (12)
  - Special Care Unit (26)
  - Respite (2)

- **West Park Healthcare Centre (132)**
  - General (26)
  - Long Term Ventilator Assistance Residents (22)
  - Assisted Ventilatory Care (32)
  - Adult Physically Disabled (26)
  - MS (26)
Discharge/Transfer Checklist for Transfer of Patients to Inpatient Rehab/CCC

• Checklist developed by the GTA Rehab Network as part of standardized inpatient rehab/LTLD rehab referral form package

• Checklist highlights that inpatient Rehab/CCC programs should be notified before patient transfer if:
  » Patient requires medications not usually available in a rehabilitation pharmacy
  » Any changes in infection status
  » New IV insert
  » Significant change/deterioration in medical condition
Discharge/Transfer Checklist for Transfer of Patients to Inpatient Rehab/CCC

If the following information is not included in your discharge summary report, please attach the most recent and relevant documents for the information below.

<table>
<thead>
<tr>
<th>Relevant Investigations</th>
<th>Status Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Labwork</td>
<td>□ Patient care plan</td>
</tr>
<tr>
<td>□ CT scan report</td>
<td>□ Current voiding status</td>
</tr>
<tr>
<td>□ MRI Scan report</td>
<td>□ Current diet orders</td>
</tr>
<tr>
<td>□ ECG</td>
<td>□ Current medication administration record (MAR)</td>
</tr>
<tr>
<td>□ INR (5 day coumadin dose history)</td>
<td>□ IV Therapy</td>
</tr>
<tr>
<td>□ Videopharyngeal Swallowing report</td>
<td>□ Current Infection Control Status</td>
</tr>
<tr>
<td>□ Chest X-ray report</td>
<td>□ Current wound management</td>
</tr>
<tr>
<td>□ Other (specify)</td>
<td>□ G-tube feeds/type/tube size/schedule/change date</td>
</tr>
<tr>
<td></td>
<td>□ Ostomy</td>
</tr>
<tr>
<td></td>
<td>□ Current O₂ rate and flow</td>
</tr>
<tr>
<td></td>
<td>□ Advance Care Directives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Reports</th>
<th>Follow Up / Treatment Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Consultation notes</td>
<td>□ Type of Appointment</td>
</tr>
<tr>
<td>□ Medical discharge summary</td>
<td>□ Appointment Date/Time/Location</td>
</tr>
<tr>
<td>□ Last OT, PT, SLP, SW assessment and progress notes</td>
<td>□ Preparation Required</td>
</tr>
</tbody>
</table>

If the following information is not included in your discharge summary report, please attach the most recent and relevant documents for the information below.
Finding the right rehab program is just a click away…

http://rehabfinder.gtarehabnetwork.ca/

Rehab Finder is the Network’s searchable database of rehab programs/clinics/single services provided by Network members.

The program-specific information within Rehab Finder is managed by designated Information Coordinators & Record Administrators at each organization, who are reminded to update their records twice per year.
• Rehab Finder was developed to…
  » Support the referral process by providing easy access to comprehensive information on rehab programs as well as programs for specific populations
  » Provide clear information on admission criteria using a standardized template to increase the transparency and accountability of the referral process and admission criteria
  » Improve our system planning capability by providing information on the current capacity and distribution of rehab programs across the GTA, which can be used to identify gaps that may exist
Quick Reference Referral Guideline

http://www.gtarehabnetwork.ca/quick-reference-referral-guide

The Quick Reference Referral Guide to Inpatient Rehab, CCC and Palliative Care:

» A **printable, easy-to-read overview** of discharge options to facilitate discharge planning discussions/decisions between the care team and patient/family.

» Provides definitions of HTSD, LTLD and CCC and a brief summary of publicly-funded programs offered by members of the GTA Rehab Network that accept external referrals.

» Information is categorized in 3 formats:
  - All rehab, CCC and Palliative care programs offered by each organization
  - Rehab & LTLD rehab programs
  - CCC programs
Baycrest Hospital
Complex Continuing Care
Rehab Programs (HT / SSR)

Elizabeth Villar-Guerrero, RN, BScN., MSN/Ed., Rehab Clinical Manager
Lina Neves, MSW, RSW, Social Worker (CCC)

July 19, 2012
Philosophy of Care

• Providing patients quality of life within the scope of the patient’s condition
• Inter-professional approach to meeting physical, emotional, social and spiritual well-being
• Client and family-centered
• Non-sectarian; principles of Judaism guide daily operations (Kosher facility)
Complex Continuing Care
5E/5W & 6E
Admission Criteria

- Age 60 and greater
- Complex chronic illness with multiple co-morbidities that require ongoing medical intervention
- Terminal medical conditions requiring end of life care with a prognosis > 3 months
- Compromised skin integrity > Stage 2 (including VAC Therapy)
- Tracheosotomy (Shiley)
- PICC lines
- Enteral Feeding tube (G/J –tube)
- Nephrostomy tubes
The program cannot accommodate…

- Patients who require O2 concentration greater than 50%
- Ventilated patients
- Patients receiving dialysis (hemo and peritoneal)
- Patients whose medical condition will in the future, require dialysis or ventilation (i.e. ALS)
- Patients who require IV chemotherapy on site

Case by case consultation required for:

- Behavioural issues
- Special equipment needs (e.g. special mattress)
- Wandering risks
To Note…

- All CCC patients pay a ministry mandated co-payment
- CCC is not a permanent or long-stay program.
- Leave of absence- beds held up to 14 days
Tips for completing a CCC referral

• Be specific in identifying the patient’s goals for CCC
• Include notes re: discussions around philosophy of care held with patient/family
• Include notes around discharge destinations that have been explored, even if applications made were declined (example: applications made to SSR, LTCH, etc.)
Contact
(Patient Flow Coordinator / CCC Intake)

Gina Dolezel
416.785.2500 ext. 2328
gdolezel@baycrest.org
Rehab Program

High Tolerance (3 West)

Slow Stream Rehab (7 East)
High Tolerance Rehab Unit (24 beds) is located on 3 West of Baycrest Hospital

| Patient Population served | Patients from acute care hospitals with diagnoses of  
|                          | ➢ stroke  
|                          | ➢ fractures  
|                          | ➢ musculoskeletal disorders,  
|                          | ➢ deconditioned with extended hospital stay due to post surgery and/or medically complex with multiple co-morbidities  
|                          | ➢ patients with PICC lines or requiring CSCI, wound care etc.  
| Age                      | age 55 and above  
| Admission criteria        | Has rehab goals and realistic discharge plan.  
|                          | Requiring short stay rehab with high intensity therapies of up to 3 hours per day, 5 days per week.  

## Demographics

Data extracted from 2011/2012 annual report from Canadian Institute of Health Information

<table>
<thead>
<tr>
<th>Information</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of admissions</td>
<td>281</td>
</tr>
<tr>
<td>Mean Age</td>
<td>83</td>
</tr>
<tr>
<td>Mean LOS</td>
<td>30</td>
</tr>
<tr>
<td>Mean Admit FIM</td>
<td>85 (out of a total of 126)</td>
</tr>
<tr>
<td>Mean Change in FIM</td>
<td>16</td>
</tr>
<tr>
<td>Mean Admit Cognitive score</td>
<td>30</td>
</tr>
</tbody>
</table>
| Discharge destination             | Discharge to home and other community settings  76%  
                                     | Clients D/C home who were at home prior to admission  70%  |
**Slow Stream Rehab (30 beds) is located on 7 East of Baycrest Hospital**

<table>
<thead>
<tr>
<th>Patient Population served</th>
<th>Patients from acute care hospitals with diagnoses of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>stroke</td>
</tr>
<tr>
<td></td>
<td>fractures</td>
</tr>
<tr>
<td></td>
<td>musculoskeletal disorders,</td>
</tr>
<tr>
<td></td>
<td>deconditioned with extended hospital stay due to post surgery and/or</td>
</tr>
<tr>
<td></td>
<td>medically complex with multiple co-morbidities</td>
</tr>
<tr>
<td></td>
<td>patients with PICC lines or requiring CSCI, wound care etc.</td>
</tr>
<tr>
<td>On admission, SSR patients generally have much lower activity tolerance, many requiring mechanical lifts or 2 person’s heavy transfers.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>age 65 and above</th>
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<tbody>
<tr>
<td>Admission criteria</td>
<td>Has rehab goals and realistic discharge plan.</td>
</tr>
<tr>
<td></td>
<td>Initially able to tolerate and participate in therapy 3 times per week, 20-30 minutes per day and progress to one hour therapy 5 times per week.</td>
</tr>
</tbody>
</table>
## Demographics

Data extracted from 2011/2012 from our own internal software system

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of admissions</td>
<td>100</td>
</tr>
<tr>
<td>Mean Age</td>
<td>82</td>
</tr>
<tr>
<td>Mean LOS</td>
<td>88 (LOS 60 to 90 days based on consistent functional gains / progress)</td>
</tr>
<tr>
<td>Mean Admit FIM</td>
<td>56</td>
</tr>
<tr>
<td>Mean Change in FIM</td>
<td>18</td>
</tr>
<tr>
<td>Mean Admit Cognitive Score</td>
<td>21.4</td>
</tr>
<tr>
<td>Discharge destination</td>
<td></td>
</tr>
<tr>
<td>Discharge to home and other community settings</td>
<td>67 %</td>
</tr>
<tr>
<td>Clients D/C home who were at home prior to admission</td>
<td>51 %</td>
</tr>
</tbody>
</table>
Referral Information:

- Weight bearing status (50% partial weight bearing)
- Intermittent oxygen (1 to 2 L/min)
- Mechanical lifts (based on unit resources; reviewed on a case by case basis)
- Enteral feeding (G/J tubes)
- CIPAP (client must be using this already)
- Ostomy and wound management
- Discharge destination and/or contingency plans if unable to return home
- Special equipment needs (e.g. bariatric equipment, special mattress)
- Cognitive testing completed with scores (e.g. MoCA, MMSE)

Exclusion Criteria:

- No VAC therapy
- No NG / TPN
- Chest tubes
- No active radiation, chemotherapy, ongoing blood transfusions, dialysis
The Client:

- Able to participate in his/her therapy sessions
- Consistent functional gains / progress
- Carry over of therapy / tasks
- Able to follow instructions
- Mild to moderate cognitive impairment

Case by case consultation required for:
- Delirium (acute)
- Behavioural issues
Contact

Angela Chan, Rehab Program Director
416.785.2500 ext. 2674
achan@baycrest.org

Elizabeth Villar-Guerrero, Clinical Manager
416.785.2500 ext. 3473
evillar-guerrero@baycrest.org

Jill Conway, Admissions Coordinator
416.785.2500 ext. 2311
jconway@baycrest.org
Where We Deliver Care

In Hospital

• **Inpatients**: 308 complex care (which includes LTLD) and 96 rehab patients (404 beds total)

• **Outpatients**: Day Treatment (20,000 visits/year)
Our programs and services are divided into 4 streams…….

- Medical Services
- Neurological Services
- Musculoskeletal Services
- Complex Care Services
Neurological Rehab, Neurological Support and Activation, and Neuromuscular Support and Activation: 65 beds

32 Rehab beds

33 Activation (LTLD) beds

Patients in this service have suffered a recent (within the past 12 months) neurological illness or injury, a stroke, acquired brain injury or an exacerbation of a progressive neuromuscular disease, excluding spinal cord injuries.

The rehab program provides intensive rehabilitation for up to 6 weeks.

The LTLD program provides rehabilitation 3 days per week for up to 12 weeks.
Bridgepoint Hospital - current areas of clinical focus

Medical Rehab and Medical Activation: 93 beds
24 Rehab Beds
69 Medical Activation

A wide range of services is provided to individuals with varying diagnoses who no longer need to be in an acute care setting, yet require interdisciplinary assessment and intervention. These patients may have had a prolonged and complicated ICU stay following a major medical illness or surgery. Patients are often older or are more de-conditioned and require a longer period of moderately intensive rehabilitation. Many have complex wound management issues. Most patients will return to community living or may require a transition to long term care.

The rehab program provides intensive rehabilitation for up to 10 weeks.

The LTLD program provides rehabilitation 3 days per week for 12 to 16 weeks.
Musculoskeletal Rehabilitation and Orthopedic Activation: 73 beds

40 Rehab beds

33 Activation (LTLD) beds

Primary diagnosis includes hip fractures, elective surgeries – i.e. back surgery and joint replacements (hip, knee, elbow, shoulder, ankle), post-fracture, multiple trauma and other musculoskeletal disorders and injuries

The rehab program provides intensive rehabilitation from 1 to 6 weeks depending on the type of surgery/injury.

The LTLD program provides rehabilitation 3 days per week for up to 12 weeks.
Bridgepoint Hospital - Current Areas of Clinical Focus

**Complex Care Services, 173 beds in total**  
Complex Care 100 beds  
Generally, patients admitted to this service are affected by mild cognitive impairment, brain injury, stroke, neuro-degenerative disease, or other chronic illnesses or have multiple medical conditions. In general, these patients are medically stable, not dependent on technology, nor do they require extensive rehabilitation. Due to their specific care requirements, or their need for specialized mobility devices, their care needs cannot be met solely with community support or in a long-term care facility.

**Palliative Care:**  
33 beds  
The Palliative Care service provides care to individuals in the end stages of terminal illness. Care is extended not only to the patients, but also to their families and friends. We believe in a holistic approach to care where a skilled inter-disciplinary team meets the patient’s physical, psychosocial, spiritual and cultural needs. The level of care required cannot be met by long-term care facilities or through community support. For patients who wish to remain at home for as long as possible, applications go on a waiting list and are activated only when they are ready for admission.

**Dialysis:**  
36 hemo beds, 4 PD beds  
The Dialysis Service provides inpatient peritoneal dialysis and, in partnership with The Scarborough Hospital, inpatient hemodialysis. Patients typically have other medical problems requiring inpatient treatment in a facility, preventing them from receiving dialysis in the community or in their own home. The level of care required cannot be met by long-term care facilities or community support but can be met in a complex care facility.
Admitting and Utilization at Bridgepoint

Admitting Department Hours 7:30am to 4:30pm Monday to Friday
416-461-8252 x2064

Utilization Department – 5 utilization specialists – who review all referrals

Referrals are reviewed for ALL programs at Bridgepoint. If the referral is more appropriate for a different service than what it was referred to, it will be redirected to by utilization using the redirect functionality (i.e. MSK rehab – redirected to Medical rehab.)
Bridgepoint Hospital - Special Services

- Wound Care
- Seating
- Augmentative Communication
- Chiropody
- Dental Clinic
- Ophthalmology
- Wellness
- Hospital-Wide Recreation
Bridgepoint Hospital – Other Services

On-Site
- Pharmacy
- Lab (Bloodwork and ECG)
- X-ray
- Some Ultrasounds

Referred Out
- Ultrasound
- MRI
- CT Scan
- Other more complicated diagnostics
Day Treatment Program

- **Musculoskeletal Rehabilitation Program** serves patients who have had orthopaedic surgery (including joint replacements), complex fractures, multiple traumas, rheumatic disease and complex soft tissue injuries.
- **Neurological Rehabilitation Program** serves patients who have had an acquired brain injury, a cerebrovascular accident, or a neuromuscular disorder.
- Both programs use a **multi-disciplinary team approach**: physiotherapy, occupational therapy, speech language pathology, social work, nursing, physiatry, and neuro-psychology.
Bridgepoint also offers several specialized outpatient clinics:

- **Primary Total Knee Replacement Program** admits patients directly from acute care immediately following discharge and provides them with comprehensive rehabilitation.
- **Primary Total Hip Replacement Program** admits patients six weeks following acute care discharge and provides them with education and exercise demonstrations.
- **Vocational Rehabilitation** provides clients with vocational goal setting, transferable skills analysis, return to work or volunteer coordination, and work site assessment.
- **Pain Management Group** uses a cognitive-behavioral approach with physical activity to provide coping strategies to people living with a chronic pain condition.
- **Young Stroke Survivor Peer Support Group** offers young stroke survivors (18-55) with education, socialization and emotional support.
Day Treatment Program

Bridgepoint has one of the only outpatient programs in the GTA that accepts referrals from external sources.

**Referral Process**
- Download referral form from Bridgepoint website
- Physician completes and signs referral form
- Fax the form to Day Treatment office 416-461-2089

**Who is Eligible?**
- 18 years of age or older
- medically stable and actively followed by a physician
- able to have transportation to and from the hospital organized prior to the first visit
- able to participate in an active rehab program
- continent or able to manage incontinence
- able to achieve functional rehabilitative goals within a short-term period (~8-10 weeks)

**Further Information?**
- Call Day Treatment office 416-461-8252 ext. 2371
Thank you!

A team will outperform a group of individuals every time!
Providence Healthcare Programs
Presented to: GTA Rehab Network & TC LHIN Hospitals
Date: October 11, 2012
Providence Hospital

- 2,000 patient admissions annually
- Provides rehabilitation following illness or surgery
  - Stroke and Neuro
  - Geriatric
  - Orthopaedic and Amputee
- Palliative care
Providence Community Centre

- 32,000 outpatient visits per year
- Adult Day Program
- Clinics
- Wellness Programs
- Scotiabank Learning Centre
Cardinal Ambrozic Houses of Providence

- New building opened in 2000
- 288 Residents
- 75% Catholic; other faiths are represented and respected
- Shorter lengths-of-stay
Changes at Providence

• Embarked on a 5 year service redesign project called Transformation by Design®
  
  Key Objectives:
  – Align patient flow processes and patient care practices to improve clinical outcomes, efficiencies and the patient experience
  – Streamline the pre-admission, inpatient to outpatients transitions
  – Become more patient-centred and interprofessional in our care model
  – Build outpatient capacity, acknowledging that recovery continues long after patients leave us

• As part of this process we are systematically decreasing the number of inpatient beds and shifting the resources to build our outpatients programs

• We’ve recently updated our Referring Professionals Guide
<table>
<thead>
<tr>
<th>Then</th>
<th>And Now...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1997/1998</strong></td>
<td><strong>2011/2012</strong></td>
</tr>
<tr>
<td>Total Admissions: 817</td>
<td>Total Admissions: 2168</td>
</tr>
<tr>
<td>% Discharged Home: 39%</td>
<td>% Discharged Home: 78%</td>
</tr>
<tr>
<td>Average Length of Stay: 200+ days</td>
<td>Average Length of Stay: 45 days</td>
</tr>
</tbody>
</table>
PROGRAM CRITERIA REVIEW
Key Messages We Are Delivering to Patients and Families

- Only part of your recovery will happen as an inpatient
  - **Inpatient Phase 1:** Improving the patients’ abilities while staying with us.
  - **Outpatient Phase 2:** Recovery while living at home, learning to adapt to their new life.

- Our primary objective is to exhaust all options to help you return home
  - Even if temporarily, while you sort out your long term options

- Your friends and family are an important part of your recovery

- Come prepared to participate!

- Patients and families are responsible for transportation to/from follow up appointments

- If you would like to request a preferred accommodation, please make that request known in advance if possible and bring insurance information and/or credit card
The following Special Needs can be accommodated but we have limited resources

- Therapeutic surfaces/mattresses
- CADD Pumps
- Bariatric equipment
- VAC wound therapy
- Suctioning machines
- High intensity oxygen
- G-tubes
## Stroke and Neuro Rehabilitation

<table>
<thead>
<tr>
<th>High Tolerance Short Duration</th>
<th>Low Tolerance Long Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Average LOS 30 Days</td>
<td>• Average LOS 45-60 Days</td>
</tr>
<tr>
<td>• Average Admission FIM 55-75</td>
<td>• Average Admission FIM 45-65</td>
</tr>
<tr>
<td>• Independent pre-morbidly with mobility and ADLs</td>
<td>• Sitting tolerance of 60 min daily</td>
</tr>
<tr>
<td>• Able to tolerate 2 hours of therapy 5 days per week, as well as participate in additional self-directed therapeutic activities daily</td>
<td>• Evidence of improvement with therapy</td>
</tr>
<tr>
<td></td>
<td>• Able to tolerance 30 min or more of therapy 3-5 times per week, as well as participate in additional self directed and group therapeutic activities</td>
</tr>
</tbody>
</table>
Orthopaedic and Amputee Rehabilitation

High Tolerance Short Duration
- Average LOS of 20 days for ortho and 40 days for amputees
- Able to tolerate 60 min or more of therapy 5 times per week
- 60 min of sitting tolerance
- As well as participate in additional self directed therapeutic activities
- WBAT

Low Tolerance Long Duration
- Average LOS <60 days
- Able to tolerate 60 min or more of therapy at least 2-3 times per week
- 60 min of sitting tolerance
- As well as participate in additional self directed therapeutic activities
- Can be PWB or NWB but Fracture Clinic Reassessments must fall within our LOS
Geriatric Rehabilitation

High Tolerance Short Duration
- Average LOS 30 days
- Independent pre-morbidly with mobility and ADLs
- Able to tolerate 60 min or more of therapy 5 times per week
- As well participate in additional self directed therapeutic activities

Low Tolerance Long Duration
- Average LOS 42 days
- Able to tolerate 60 min or more of therapy 3-5 times per week
- 60 min of sitting tolerance
- As well as additional self directed and group therapeutic activities
Palliative Care

- We have both an active and back up waitlist system
- Require a DNR status order and discussion to happen in advance of application
- Prognosis of 1 month or greater
- Completed PPS and ESAS scores
- **KEY:** Overall care needs must warrant PCU level care at point of application
- We do successfully transition patients home and to long term care, if/when their condition stabilizes such that their care needs can be met in a different environment
- We accept applicants from acute and home
  - Our home applicants do get priority if they reach out in distress
- We have a comfort care philosophy that does not support prolonged supplementary hydration
- All active treatments and diagnostics must be completed
Our Contact Information

Karen Hunter
Patient Flow Manager
416-285-3666 Ext. 4382

Kimberly MacKenzie
Acting Patient Flow Manager
416-285-3666 Ext. 3779
(effective Nov 2012 – July 2013)

Main Admitting Hotline  416-285-3744
Main Admitting Fax    416-285-3759
AGENDA

• Overview of RHC
• Clinical Services
• Independently Operated Clinics
• Admission Criteria
  - Medically Complex Program
  - LTLD Rehabilitation Program
• Admission Process
• Bed Availability
OVERVIEW OF RHC

625 Runnymede Road
Toronto, ON
M6S 3A3
Phone: 416-762-7316
OVERVIEW OF RHC

200 bed Complex Continuing Care Hospital

- 121 Medically Complex beds
- 46 Low Tolerance Long Duration Rehabilitation (LTLD Rehab) beds
- Planning for 33 bed specialty wound care unit
CLINICAL SERVICES

• Daily medical coverage
  ➢ 5 GPs

• Consultants
  ➢ Geriatrician, Psychiatrist, Optometrist, Physiatrist, Respiratory Therapist

• Nursing mix
  ➢ RNs, RPNs
CLINICAL SERVICES (cont’d)

• Allied Health
  ➢ Clinical Nutrition
  ➢ Occupational Therapy
  ➢ Pharmacy
  ➢ Physiotherapy
  ➢ Activation Therapy
  ➢ Social Work
  ➢ Speech Language Pathology

• Lab & Diagnostic Services
Independently Operated Clinics - Inpatients & Outpatients

- Runnymede Dental Centre
  - Dr. Natalie Archer

- Runnymede Footcare Centre
  - Dr. Paul Scotti

✓ Onsite, wheelchair accessible services
ADMISSION CRITERIA – Medically Complex

Patients are accepted with specialized needs:

- Uncuffed tracheostomy
- Continuous positive airway pressure (CPAP)
- Enteral feeding
- Intravenous therapy including PICC Lines
- Continuous oxygen
- Potential for functional improvement
- Wandering risk due to mild cognitive impairment
- Wound Care
EXCLUSION CRITERIA – Medically Complex

Patients requiring/with:
- Chronic ventilation
- Cuffed tracheostomy
- Blood gas determinations
- Weight greater than 300lbs
- Hemo or peritoneal dialysis
- Severe mental health issues
- Total parental nutrition (TPN)
ADMISSION CRITERIA – LTLD

Admission inclusion criteria includes patients who:

- Are medically stable
- Demonstrate potential to achieve functional improvement
- Can tolerate a minimum 60 mins sitting out of bed
- Can weight bear a minimum of 50% (25-50% weight bearing may be considered)
- Has a realistic and appropriate discharge plan in place
EXCLUSION CRITERIA – LTLD

Patients requiring/with:

- Severe attention, judgment, alertness or orientation deficits
- Intensive cognitive rehab or behaviour management
- Symptomatic drug or alcohol withdrawal
- Treatment for co-morbid illness or conditions that interfere with his/her ability to participate in rehab
ADMISSION PROCESS

• How to refer to RHC
  ➢ E-referral

• Important information required
  ➢ For acceptance of the referral
    • Medication Administration Record (MAR)
    • Lab results for VRE, MRSA & C Difficile
    • Accommodation preference
  ➢ For admission planning
    • Progress notes as applicable
ADMISSION PROCESS (cont’d)

• Acceptance or denial of application provided within 2 business days

• Application waitlisted if bed not available

• Pre-admission tours available upon request for accepted applications
BED AVAILABILITY

• 3 floors with 2 units/floor

• Accommodation Type
  ➢ Private beds with private/shared washroom
  ➢ Semi-private beds with shared washroom
  ➢ Ward beds (4 patients/room)
    • Preferred accommodation rates differ from LTC
    • Co-payment calculation the same as LTC
PATIENT FLOW CONTACT INFORMATION

• Diana Morris
  Senior Patient Flow Coordinator
  T: 416.762.7316 ext. 2261

• Lisa Dreher
  Patient Flow Coordinator
  T: 416.762.7316 ext. 2228

Fax: 416.762.5386
Email: PatientFlow@runnymedehc.ca
Rehab Program Overview

Justin Stone – Patient Services Manager
Our IP Programs

- Amputee
- Burn
- Cardiac
- MSK
- Oncology
- Organ Transplant
- STAR
- Neuro
- Trauma
Admission Criteria

Applicable to all programs:

- Medically stable with no significant fluctuations in medical status within 72 hours
- Motivated to participate in rehab; has active rehab goals and able to participate in 2 sessions of active therapy daily
- Patient’s cognitive abilities and state of mental health support participation in active rehab.
- Able to sit unsupported for 30 minutes
Special Needs

- The following special needs are generally accepted, though assessed on a case by case basis:
  - IV Therapy (PICC and portacath only)
  - Intermittent oxygen therapy
  - Tracheostomy (must be corked)
  - Intermittent PEG tube feeds
  - Offsite Dialysis (arranged prior to admission, patient responsible for transport to and from)
Hip Fracture Patients

• Admitted as part of our MSK program

• Target LOS is 4-5 weeks

• Weight bearing status must be congruent with the patients functional goals during their rehab stay
Hip Fracture Patients

- Patients who will likely require more than 6 weeks of high intensity rehab are recommended to seek LTLD programs

- MMSE score target range of 20 or greater
  Patients are often admitted with lower scores as long as they are able to actively participate in therapy sessions
The STAR Program

STAR = Short Term Active Reconditioning

- Often from a general medical or general surgical stream; with an acute care stay of greater than 4 weeks
- Primarily Geriatric
- Focus on general strengthening over the course of admission (up to 3 weeks)
- Often, patients who don’t ‘fit’ well into our other programs are offered admission under the STAR program
Facilitating Flow

Information we often request in relation to our applications:

• Clear information re: destination post rehab stay
• Objective information r/t the patients current level of participation
• Objective information r/t functional level pre-hospitalization stay
• Follow up support for complex needs (i.e. psychiatric follow up)
Facilitating Flow

• Medical History – What do we need to know?
  • The patients medical history will likely impact the 4 generalized criteria mentioned earlier
  • The patients medical history requires a service we cannot support (i.e. continuous oxygen)
Questions
Toronto Grace Health Centre

Jake Tran
Overview

- Located DT at 650 Church Street. (Church and Bloor)
- 119 Bed Facility
- 4 Floors
Programmes

- 6th Floor Palliative Care (3 months Stay)
- 5th Floor CCC and SPR 12
- 4th Floor CCC and SPR 10
- 3rd Floor CCC

- 6th Floor 19 Beds
- 5th Floor 32 Beds
- 4th Floor 34 Beds
- 3rd Floor 34 Beds
- Total: 119 beds
DISCUSSION

• Most Recent OT/PT notes
• Patient’s most recent lab work/infection control issues
• SW Notes/Plan for discharge home established
• Dietician notes if applicable
• Nursing Report:
  Wounds/behaviours/psychiatric history/cognitive issues/ADLS/special equipment needed
CCC PROGRAM AT TORONTO REHAB
The E.W. Bickle Centre’s Location

130 Dunn Ave. Toronto
Complex Continuing Care Streams

- **Complex Medical Stream** – 170 Beds
- General CCC – 146 Beds
- Hemodialysis -12 beds
- Palliative Care – 10 beds
- Respite Care – 2 beds

- **Low Tolerance Long Duration Stream** – 38 Beds
  - Functional Enhancement
  - Neuro-Physical
Referral Methods

• RM&R
• eStroke
• Fax
  – GTA Rehab Network Inpatient Rehab/CCC Form
  – Toronto Central Palliative Care Network Referral Form
General CCC Admission Criteria

• 18+ years of age
• Require regular nursing and medical intervention. May include management of:
  – Airways (eg. Tracheostomies, CPAP)
  – Pain and symptoms
  – Complex wounds
  – Complex medication administration (eg. PICC lines)
General Admission Criteria, Cont’d

- Advanced physical and/or cognitive challenges limiting independent community living
- Verbal/physical responsive behaviours assessed on a case-by-case basis
- Must have sufficiently complex needs as assessed using CCRS
Hemodialysis Admission Criteria

• Same as General CCC, except:
  – No tracheostomies
  – No enteral feeding during dialysis treatment and travel time
  – Must be able to tolerate travel to 550 University Avenue dialysis suite three times per week
Palliative Care Admission Criteria

- Diagnosis of end-of-life illness
- Life expectancy of 3 months or less
- Difficulty with pain management requiring symptom relief, or other complex care needs
Respite Care Admission Criteria

• Same criteria as General CCC
• Up to 14 day stay
• Patient must come from the community
• There is a fee for this service
LTLD Admission Criteria

• Medically stable and rehab ready
• Requires less intense, long duration rehab
• Demonstrates carryover and a potential for functional progress
• Able to consistently follow simple verbal/visual commands
LTLD Admission Criteria, Cont’d

• 30-minute therapy tolerance; 60-minute sitting tolerance
• Responsive behaviours assessed on a case-by-case basis
• Well-established, realistic discharge destination in the community
LTLD Admission Criteria, Cont’d

- **Functional Enhancement**
  - Weight-bearing status assessed on a case-by-case basis
  - Goals achievable within 75 day maximum length of stay
- **Neuro-Physical**
  - Ranchos Los Amigos of 4 or more
  - Goals achievable within 90 day maximum length of stay
Contact Information

• General Admissions Inquiries:
  – 416-597-3422 x2504

• Admissions Service Coordinator:
  – 416-597-3422 x2220

• Fax:
  – 416-530-2470
Geriatrics and MSK Program Locations

- Geriatrics Program is located at University Centre
- MSK Program is located at Hillcrest Centre
  - MSK Program to move to University Center by Jan 2013
Referral Methods

- RM&R
- Fax
  - GTA Rehab Network Inpatient Rehab Form
# Geriatrics Program

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>PATIENT POPULATION</th>
<th>INPATIENTS University Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Geriatric Rehab</strong></td>
<td>• Frail</td>
<td>25 beds</td>
</tr>
<tr>
<td></td>
<td>• Medically complex</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Multiple co-morbidities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Deconditioned/mobility</td>
<td>(12 dialysis and 13 rehab beds)</td>
</tr>
<tr>
<td><strong>Geriatric Psychiatry</strong></td>
<td>• Advanced dementia</td>
<td>20 beds</td>
</tr>
<tr>
<td></td>
<td>• Alzheimer’s</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Challenging behaviour</td>
<td></td>
</tr>
</tbody>
</table>
Geriatrics Rehab – Admission Criteria

• **Age criteria:**
  – 65 years and older
  – Discharge destination following rehab should not be a LTC facility

• **Activity tolerance:**
  – Supported sitting for >60 minutes, unsupported sitting for ~10 min
  – Supported standing with assist of 1-2 for >10 minutes
  – Active participation in 1-2 hours/day therapy / group sessions
  – Active engagement in ADLs
    (grooming, bathing, dressing and toileting)
Geriatrics Rehab – Admission Criteria

• Cognition & Behavior:
  – Motivated and can participate in an active rehab program
  – Can follow instruction and demonstrate new learning
  – Can engage in decision making process
  – Stable for a psychiatric perspective, no behavioral issues such as wandering, aggression or exit seeking

• Medical:
  – Medical condition is stable and will not interfere with ability to participate (not palliative or degenerative)
  – Able to maintain O2 saturations at rest with \( \leq 2\text{l O2} \)
  – Does not have undiagnosed weakness
  – Does not have uncontrolled pain
Geriatrics Dialysis – Admission Criteria

- Admission Criteria is the same as Geriatrics Rehab with the following exceptions:
  - Age criteria of 60 years and older
  - Dialysis requirement

- Please note that patients must be able to tolerate activity tolerances as indicated in previous slides
# MSK Program

<table>
<thead>
<tr>
<th>STREAMS</th>
<th>PATIENT POPULATION</th>
<th>INPATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology</td>
<td>• Oncological diagnoses including: MSK involvement (bone and tissue), colorectal cancer, lung cancer, renal cancer, etc.</td>
<td>5 Beds</td>
</tr>
<tr>
<td>Trauma</td>
<td>• Any fractures and soft tissue injuries due to high velocity/high impact injury (i.e. MVC, workplace accident, fall from height)</td>
<td>8 Beds</td>
</tr>
<tr>
<td>FHRAT</td>
<td>• Any type of proximal femur/hip fracture or periprosthetic fracture of the femoral component.</td>
<td>22 beds</td>
</tr>
<tr>
<td>Complex MSK</td>
<td>• Any other type of orthopedic involvement (i.e. fractures, tendon repairs, or some spinal surgery) • Will consider multiple medical diagnoses as well.</td>
<td>25 beds</td>
</tr>
</tbody>
</table>
MSK Rehab – Admission Criteria

• Program Overview

  – A High Tolerance Short Duration Program
  – Patients must have rehabilitation potential. Must be able to actively participate 1-2 hours per day in therapy
  – Age 18 and over
  – Discharge destination following rehab should not be a LTC facility
  – Pt. should not be reliant on a mechanical lift as a routine method of transfer. Referral will be evaluated case by case, in consultation with Service Coordinator.
  – Will consider admitting patients directly from convalescent care and community
MSK Rehab – Admission Criteria

• Cognition

  – Patients with severe cognitive impairment will be considered on a case by case basis (e.g. Mini-Mental scores less than 10)
  – Must be able to follow caregiver instructions and demonstrate carry over/new learning
  – Patient is motivated and able to participate in an active rehab program
  – Patient must be stable from a psychiatric perspective
  – For patients with challenging behaviours (e.g. aggression, wandering, climbing out of bed, sitter required), please contact Service Coordinator
MSK Rehab – Additional Criteria

- **Oncology Stream**
  - Prognosis must be >6 months
  - Exclusion criteria include:
    - 1) Cancer involving the brain
    - 2) Cancer involving the spinal cord with moderate to severe neurological impairment
  - Patients receiving chemotherapy or radiation therapy three times per week or more should be referred when their course of treatment is completed or decreased in frequency

- **Trauma Stream**
  - Can accommodate patients with mild or moderate brain injury (will consult with ABI program as needed)
  - No restrictions with WB
Contact Information

• Geriatrics Rehab Service Coordinator:
  • 416-597-3422 x3038
  • Fax: 416-597-7067

• MSK Rehab Service Coordinator:
  • 416-597-3422 x4323 or x4537
  • Fax: 416-537-3752
Overview of Rehab, LTLD and CCC Services
October 11th, 2012

Presentation to TC LHIN Hospitals
Outline of Presentation

- Criteria for Admission to MSK/CCC/LTLD
- Referral Differentiation for LTLD
- To Expedite Referral Acceptance
- Past Medical History
- Questions
Criteria for Admission - Musculoskeletal Rehabilitation

- Catchment area: Toronto and GTA
- Complex MSK rehab, aged 18 and older
- Multiple trauma, hip/knee revisions, hip fractures, bariatric patients
- Have the ability to achieve realistic goals in 28 days
- Must be medically stable
- Must have sufficient cognitive capacity (demonstrated learning carryover)
- Identified discharge destination
Criteria for Admission – Geriatric Functional Enhancement (LTLD)

- Catchment area: Toronto and GTA
- Frail Elderly patients 55 years and older
- Must have potential for rehabilitation
- Must be medically stable
- Must have sufficient cognitive capacity
- Must have discharge destination or willing to discuss options
Patient issues managed on LTLD/MSK Services

- Bariatric
- Respiratory with oxygen – CPAP; BiPAP
- PICC lines
- IV antibiotics via peripheral line
- Wound support (Vac Therapy)
- Urinary retention
Referral Differentiation for LTLD

- Patients with hip fracture that fall off the clinical pathway in acute care due to co-morbidities
- 90 day length of stay
- Orthopaedic, medical or neurological issues
- Patient is unable to tolerate daily therapies
- Significant number of co-morbidities which compromise progression in rehabilitation
- Delirium which is resolving
Criteria for Admission – Complex Continuing Care

- Catchment area: Toronto and GTA
- Chronic illness
- Totally dependent in ADL
- At risk for recurrent exacerbations of condition
- Unpredictable medical condition
Information Needed to Expedite Referral Acceptance

- Complete and accurate referral
- Clearly identify functional abilities and progression in rehab to date (PT/OT notes)
- Clear, realistic goals
- Level of family support available
- Cognitive status and screening scores
- MAR faxed separately
- Peritoneal dialysis available on amputee rehab unit

**NOTE:** Daily treatment in acute care and excessive outside appointments impact ability of patient to participate in therapy
West Park Highlights

- Centralized admitting department to immediately respond to and field questions about referrals
- Care Coordinator on each unit to expedite the referral and provide one point of contact from referral to discharge
- Rapid Response/Code Blue team available 24/7 to respond immediately to medical emergencies, decreasing further deterioration, mortality and/or need to send patients out
Past Medical History (not relevant to current history)

- Depression/anxiety
- Urology
- Renal
- Cardiac
- Endocrinology
- Oncology
- Dietician information
- Ostomy notes

NOTE: this information is used to facilitate continuity of care and decrease duplicate tests