GTA REHAB NETWORK

Clarifying the Complexities of Inpatient Geriatric Rehab

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1.0 INTRODUCTION AND BACKGROUND

Since its inception in late 1999, the GTA Rehab Network has taken a focused approach to identifying and addressing access issues related to the movement of patients across rehab services. To date, this work has included the development of a web-based resource (*Rehab Finder*) to provide comprehensive information about inpatient, outpatient and home-based rehab programs offered by Network members in a consistent format; a standardized MSK referral form and the Inpatient Rehab Referral Guidelines to streamline and improve referral processes. In addition to these initiatives, the Network conducted an ALC survey[1] in February 2006 with three acute care hospitals to identify potential strategies to shorten the length of stay of patients awaiting inpatient rehabilitation in ALC beds. The survey found that 43% of these ALC patients awaiting rehab had been referred for geriatric rehab and accounted for the largest total number of ALC days (365 days).

As part of its strategic direction to improve service access and delivery, the GTA Rehab Network has taken into account the changes in the rehab landscape that have given rise to publicly-funded rehabilitation programs across many settings. Recognizing that variations in service scope exist across these programs, the Network has identified the need to promote consistency in rehab care and increase clarity about the rehab options that are appropriate to meet particular rehab needs. To this end, the Network embarked upon a Rehab Definitions initiative (Spring 2006) to develop a rehab definitions conceptual framework that defined the essential components of publicly-funded rehabilitation. In the fall of 2006, work was begun to expand the framework by developing population-specific definitions and standards of practice using evidence-based parameters. Through this work, the Network is laying the groundwork for improving consistency and quality of care in the programming offered across the system, reducing confusion for referrers, streamlining referral processes and establishing standards of practice to support performance measurement. This focus is also in line with the recommendations of the Ontario Hospital Association calling for clear policy directions to clarify terminology and standardize programming, admission criteria and referral processes in rehabilitation and complex continuing care.[2]

1.1 Geriatric Rehab as a Priority Focus

As the GTA Rehab Network obtained feedback on its Rehab Definitions Conceptual Framework, stakeholders reported that there was a lack of clarity in the types of rehab programs available for geriatric patients including those deemed "medically complex." Referrers also reported confusion around the characteristics of patients that could help determine which patients were appropriate for particular programs.

The rehab options that currently exist for geriatric patients in need of inpatient rehab include the following:

- Dedicated geriatric rehab programs
- Dedicated diagnosis specific rehab programs
- Mixed rehab programs that accept geriatric/complex medical patients as well as patients from other rehab diagnostic groups (e.g. MSK, Stroke)
- Complex continuing care programs that provide low tolerance long duration (slowstream) geriatric/complex medical rehab

[1] GTA Rehab Network. ALC Survey, 2006: Mapping the way to targeted solutions. (October 2006)
[2] Ontario Hospital Association. Optimizing the role of complex continuing care and rehabilitation in the transformation of the health care delivery system. May, 2006.

Within each of these types of programs, variability exists in admission criteria and the types of resources available to patients. In short, it is not always clear to referrers which program is best suited to meet the needs of their geriatric rehab patients.

The confusion among referrers about the inpatient rehab options for geriatric patients along with the ALC survey findings that patients waiting for geriatric rehab were the largest group in ALC prompted the GTA Rehab Network to prioritize geriatric rehab as one of its main areas of focus. Specifically, geriatric rehab was selected as one of the first two rehab population groups for whom population-specific definitions would be developed. Given the existing confusion around the rehab programs available for inpatient geriatric rehab and the complexity involved in matching the right geriatric rehab patients to the right types of rehab programs, the Network first focused its attention on developing definitions to describe the services provided, degree of specialization, the differential criteria, typical duration and the key activities of *inpatient* geriatric rehab.

This report summarizes the approach, the outcomes and recommendations of the GTA Rehab Network's Geriatric Rehab/Medically Complex Task Group for inpatient geriatric rehab. The recommendations that have been put forward have been done so with the recognition that the development of definitions for geriatric rehab and strategies to improve access to and the delivery of geriatric rehab is an iterative process that must take into account emerging evidence in geriatric research as well as evolving work that is being done in this area.

2.0 APPROACH

2.1 Geriatric Rehab/Medically Complex Task Group

The Geriatric Rehab/Medically Complex Task Group was convened in September, 2006. The task group included Network members from acute care, inpatient rehab, and complex continuing care programs from across the GTA Rehab Network as well as members from the Regional Geriatric Program of Toronto (RGP) (Appendix A). Given the Network's priority focus on geriatric rehab and the streamlining of referral processes for patients in ALC awaiting inpatient rehab, a decision was made by the Coordinating Council of the GTA Rehab Network to engage an external consultant with expertise in geriatrics to facilitate the achievement of the task group's objectives. Terms of Reference were developed (Appendix B) and meetings were held on a monthly basis from September 2006 to January 2007.

2.2. Project Mandate

Recognizing that delays in accessing rehabilitation can result from an interplay among various factors (e.g. capacity, staffing/equipment resource requirements, referral processes), the mandate of the Geriatric Rehab/Medically Complex Task Group was to contribute to the reduction of the number of patients in ALC waiting for geriatric rehabilitation services by developing clear definitions and criteria for the terms "geriatric," "frail" and "medically complex" and defining the key components of rehabilitation required for these patients. Issues affecting access to geriatric rehab were also identified and possible solutions proposed.

It was anticipated that by identifying the key program components of inpatient geriatric rehab, and specifying the characteristics that make patients appropriate for particular programs, referrers would have greater clarity about where to refer their patients, thus decreasing some of the delays in the referral process. By standardizing definitions for rehab across the system using evidence-based best practices, rehab programs would be in a better position to evaluate their current programming against established benchmarks and work towards creating a system in which comparable services are offered across rehab programs.

2.3. Literature Review and Key Informant Interviews

An extensive review of the literature was conducted involving over 60 articles (Appendix C). Relevant information was gathered from research resources including the Canadian Institute for Health Information (CIHI) and the British Geriatric Society (BGS). The focus of the review was to seek clarity for terms that are frequently used to describe the geriatric population (e.g. frailty, geriatric and medically complex) and identify best practices in geriatric rehab including staffing considerations and models of service.

Key informant interviews were held with geriatric researchers and clinical specialists from across the province to supplement the findings from the literature review with the first-hand clinical experiences of those working within the Ontario geriatric rehabilitation context. The key informants included 12 researchers and clinicians (Appendix D). The purpose of the interviews was to obtain some clarity regarding the differentiating criteria of rehab programs, rehab program components, and referral processes. A teleconference was also conducted with all of the key informants to discuss referral and service delivery models.

3.0 FINDINGS FROM THE LITERATURE/KEY INFORMANT INTERVIEWS

3.1 Literature Review

Frailty

There is no clear consensus on a definition of frailty among researchers or clinicians. Researchers have struggled to describe frailty from a variety of perspectives (e.g. focusing on the biological underpinnings of frailty[3] [4] versus more multidimensional views that include psychosocial aspects[5]). There is a continuum of frailty and it results from a complex interplay of a person's bio-psycho-social assets and deficits.[6] In 2003, *The Canadian Initiative on Frailty and Aging*[7] received a four year grant to develop a working framework for understanding frailty.

In the meantime, front-line care providers, educators and researchers are still looking for consensus on the meaning, measurement and application of frailty. Using current definitions of frailty, it can be broadly described as an overlapping concept with aging, disability and medical complexity. These factors together can provide an assessment of the frailty of a particular patient.

Currently, assessment of frailty makes use of tools such as the *Comprehensive Geriatric Assessment (CGA)*[8], the *Functional Independence Measure (FIM™)*[9], impairment lists or algorithms derived from clinical judgment. These tools are lengthy and/or need to be administered by a health care provider with expertise in geriatrics to interpret the findings appropriately for the geriatric patient population. Recently, a validated dynamic measure, the *Edmonton Frail Scale (EFS)*[10], has been developed as a tool for non-specialists in geriatrics to assess frailty using a brief questionnaire.

Functional Disability

The need for assistance in activities of daily living (ADL) and instrumental activities of daily living (IADL) is identified as an important indicator of frailty.[11] Because of the difficulties in defining frailty, recent research on risk factors for frailty by the Canadian Initiative on Frailty and Aging has focused on identifying risk factors for ADL and/or IADL disability.

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[3] Gillick, Muriel. Pinning down frailty. *Journal of Gerontology Medical Sciences,* 2001. Vol. 56A, No. 3, M134-M135.

[4] Fried LP, Tangen, CM, Walson J, Newman, Hirsch C, Gottdiener J, Seeman T, Tracy R, Kop WJ, Burke G, McBurnie MA. Frailty in older adults: evidence for a phenotype. *Journal of Gerontology Med Sci,* 2001.

[5] Wells JL, Seabrook JA, Stolee P, et al. State of the art in geriatric rehab. Part I: Review of frailty and comprehensive geriatric assessment. *Arch Phys Med Rehabil.* Vol 84, June 2003.

[6] Wells, 2003.

[7] CIHR. *The Canadian Initiative on Frailty and Aging*. www.frail-fragile.ca

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

[9] Functional Independence Measure (FIM™). Uniform data system for medical rehab. Buffalo, NY: Research Foundation of SUNY; 1990.

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

[11] Naglie G, Gill SS. A systematic review of risk factors for functional disability in older adults. Toronto Rehab; University Health Network. University of Toronto, Toronto Ont. And Queen's University, Kingston, Ont.

Geriatric

According to the British Geriatrics Society, the most common age of patients admitted to geriatric services is 75; however, geriatric patients may range in age from 65 to 85 years.[12] "Geriatric" is a term that is not exclusively determined by chronological age. Although geriatric rehabilitation patients are typically older, they also tend to be frail with multiple secondary illnesses and have lower functional status scores upon admission than other rehab populations.[13]

Medical Complexity/Co-morbidity

Medical complexity is a term used to describe patients who have multiple medical problems and complications, which prolong the recuperation period. These patients require medical management of the principal condition and monitoring of co-morbidities and potential complications.[14]

3.2 Key Informant Interview Findings

Availability of Geriatric Expertise

Nearly half (47%) of all patients admitted to inpatient rehab in 2003-2004 were over 74 years of age (CIHI, 2005)[15]and as the population ages, there will likely be an increasing need for geriatric rehab. In the current rehab landscape, acute care and rehab providers outside of specialized geriatric services are often not knowledgeable about the principles of geriatric care, the needs of the elderly or the use of screening instruments appropriate for this population. As a result, the potential for improved function in older rehab patients may not be well understood and acknowledged.

To address this situation, the key informants identified the need for education regarding the assessment and treatment of geriatric syndromes and the use of preventive approaches to lessen iatrogenic illness within this frail and vulnerable population. It was noted that although best practices in geriatric rehabilitation include the provision of such assessments and treatment approaches, they were not accessible to many patients who may be referred to other types of rehabilitation programs without such expertise. The key informants made note of the Level 1 evidence that assessment by a geriatric team in acute care improves outcomes. The benefits of making geriatric consultation available to all rehabilitation programs that serve elderly patients were discussed by the key informants in light of this Level 1 evidence. It was acknowledged that while this approach may be feasible in communities where one rehabilitation centre serves the needs of the entire community, in regions such as the GTA where multiple rehab centres exist, the current shortage of geriatricians precludes such a practice.

[12] British Geriatrics Society. Acute medical care of elderly people. BGS Compendium Document 3.1. (2004).
[13] Patrick L, Knoefel F, Gaskowski P, Rexroth D. Medical Comorbidity and Rehabilitation Efficiency in Geriatric Inpatients. *Journal of American Geriatrics Society,* (2001).
[14] Canadian Institute for Health Information. Rehabilitation Minimum Data Set Manual, Adult Inpatient Services (2001)
[15] Canadian Institute for Health Information. *Inpatient Rehabilitation in Canada, 2003-2004. Special Topic: A Look at the Older Population.* (2005)

Barriers to Accessing Geriatric Rehab

Candidates for geriatric rehabilitation are typically described as frail with compromised pre-morbid functioning due to multiple co-morbidities. In contrast, diagnosis-specific rehab programs focus on addressing rehab needs that stem from a recent acute event, such as a stroke. Typically, patients accepted into these programs are described as the "well elderly" with unimpaired premorbid functioning and for whom rehab is predicted to be uncomplicated and achievable within shorter lengths of stay.

The key informants identified that there was no simple objective screening tool to help referrers determine which patients are appropriate for geriatric rehab versus other types of rehab (i.e. diagnostic-specific rehab, LTLD rehab). This situation is further compounded by a lack of a common understanding and agreement about components of rehab programs for geriatric patients creating inconsistencies in who is referred and the types of services that are available to them. This lack of consistency and standardization across programs fosters inequitable access.

Barriers to accessing geriatric rehab also arise from differing procedures and information requirements for application to the various programs and confusion about where beds are available. Such considerations delay the referral process and increase wait times. From the rehab perspective, geriatric rehab programs are sometimes unable to meet the 2-day response time benchmark set out in the GTA Rehab Network's Inpatient Rehab Referral Guidelines[16] or unable to admit patients quickly because the medical resources to review applications or receive patients on admission are not readily accessible to them.

Finally, the key informants noted that long wait times in acute care for geriatric rehab increases the risk of iatrogenic illness (e.g. infection, skin ulcers, greater functional decline), which can delay rehab readiness, increase functional decline and prolong overall lengths of stay in both acute care and rehab hospitals.

[16] See the GTA Rehab Network's Inpatient Rehab Referral Guidelines, (2005)

4.0 ACTIONS

4.1 Definitions and Descriptions

Inpatient Geriatric Rehabilitation

The GTA Rehab Network's *Rehab Definitions Conceptual Framework* uses the following criteria to guide the development of definitions for each rehab sector in the continuum:

- Names Typically Used
- Services Provided
- Degree of Specialization
- Differential Criteria
- Typical Duration
- Key Activities/Nature of Service

These criteria were used to develop definitions to describe inpatient geriatric rehabilitation and to differentiate among rehab programs provided on mixed units (i.e. rehab programs that accept patients from a variety of rehab diagnostic groups, including geriatric patients); dedicated geriatric rehab programs (i.e. rehab programs that provide rehab specific to the needs of the geriatric population); and Low Tolerance Long Duration (slowstream) rehab in Complex Continuing Care (CCC). (Appendix E)

One of the guiding principles of the Definitions initiative is to define the "gold standard" of rehabilitation for each rehab population group using evidence-based parameters where available. Currently, no such gold standard in geriatric rehabilitation exists.[17] The definitions that have been developed for inpatient geriatric rehab have incorporated learnings from the literature review conducted; however, in the absence of clear best practice guidelines at the present time, the definitions around staffing, degree of specialization and differential criteria have been based on recommendations from the key informants, the Regional Geriatric Program of Toronto and current clinical practices.

Rehab Program Inventory

An inventory of rehab programs provided by Network members that accept geriatric patients was compiled and analyzed. The inventory (Appendix F) differentiates among:

- Dedicated Geriatric Assessment/Rehab Programs
- Geriatric/Medically Complex rehab on mixed rehab units and
- LTLD rehab programs in CCC that accept geriatric/medically complex patients

The inventory includes information on admission and exclusion criteria, number of beds and current staffing levels. Standards for appropriate rehabilitation staffing ratios have not yet been established in the literature[18] and due to the diversity of the programming in the programs explored, comparative staff ratios could not be meaningfully expressed. Instead, staffing ratios based on the present practices of three inpatient dedicated geriatric rehab programs of the GTA Rehab Network were used to provide an estimated range of staffing for dedicated geriatric rehab programs. (Appendix G)

[17] Borrie MJ, Stolee P, Knoefel, FD, Wells, JL. Current Best Practices in Geriatric Rehabilitation in Canada. *Geriatrics Today, Can J Geriatr Med Psychatry.* December 2005.

[18] Erlendson P, and Modrow R. National guidelines for rehabilitation staffing levels: A literature review. *Healthcare Management Forum*. 2003

Program Inventory Analysis

In all, there are 131 rehab beds and 75 complex continuing care beds dedicated to geriatric rehab that accept external referrals.[19] There are many differences across the various inpatient rehab programs that accept geriatric patients including differences in the age eligibility criteria. Some programs accept patients 60 years of age and older; some 65 years of age or older while others limit admissions to patients 75 years of age and older. There are differences in programming among programs with the same or similar names (e.g. Geriatric Assessment and Treatment Units, Geriatric Assessment and Rehab Units, Geriatric Rehab Units) and there are differences in the staffing ratios and mix among programs. It should be noted that there are also subspecialties and other services available within geriatric rehab (e.g. Geriatric Psychiatry, Dialysis).

In general, when one compares the definitions that have been developed for inpatient geriatric rehab to existing inpatient geriatric rehab programs, many of the programs meet the clinical standards that have been recommended. However, some changes will be required by organizations in order to conform to the new definitions in the rehab framework. For example, the framework is clear in the distinction between Geriatric Assessment Units (i.e. the focus is primarily on assessment and the medical management of geriatric syndromes generally within a 2 week length of stay) and Geriatric Assessment and Treatment Units (i.e. the focus is more on providing a moderately intensive rehab program to restore the functional status of the patient). As a result, organizations will need to review the terminology used to label their programs and ensure that it is consistent with the definitions developed and accurately reflects the services provided. The definitions framework also makes clear the need for medical expertise in geriatric care and multi-system issues across all rehab programs that provide geriatric rehab. To conform to this recommendation, some of the rehab programs provided on Mixed Units and LTLD programs in CCC that provide Geriatric/Medically Complex Rehab will need to upgrade their staffing to ensure that, at a minimum, their medical staff has such expertise. Such efforts will serve to increase consistency in the programming offered across rehab programs and reduce confusion for referrers.

4.2 Triage Guidelines

In addition to developing definitions to describe and distinguish among the types of geriatric inpatient rehab programs, a four page tool, the *Inpatient Rehab Triage Guidelines for Geriatric Patients* (Appendix H) was developed to further increase clarity for referrers. The triage guidelines are for use by front-line clinicians to assist them in determining the appropriate type of rehab program for particular types of patients. The new triage tool incorporates the criteria of the GTA Rehab Network's *Inpatient Rehab Referral Guidelines* to first determine if the patient is a candidate for inpatient rehab, medically stable and rehab ready. Next, it considers if the patient's premorbid functioning was impaired and/or if the patient has current multi-system needs. It then triages the patient based on therapeutic activity tolerance level. Finally it considers the need for a rehab program with clinical expertise in geriatrics in order to finalize the referral decision. If, on the other hand the key reason for rehab is to address functional impairment arising from a recent acute event without the presence of pre-morbid functional impairment, only therapeutic activity tolerance level is used to determine the appropriate referral.

The triage guideline was developed with input from acute care and rehab clinical teams in organizations represented by the task group members; however, a more formalized evaluation of the tool by acute care and rehab hospitals is underway to assess if the rehab destination suggested by the triage guidelines is appropriate. The evaluation is being conducted on General Medicine and Orthopaedic units in acute care and dedicated geriatric programs in rehab and LTLD programs.

[19] These figures are based on information available as of December 2006.

5.0 SUMMARY AND ANALYSIS

There are many different types of rehab programs in the GTA that accept geriatric patients. They include:
- dedicated geriatric rehab
- dedicated diagnosis specific rehab
- mixed rehab
- LTLD geriatric/medically complex rehab in CCC

Faced with making decisions about where to send their patients for rehab, referrers in acute care have had no guidelines to assist them in choosing the most appropriate program.

To address this issue, the GTA Rehab Network undertook the task of trying to clarify and streamline the referral process for inpatient geriatric rehabilitation. In order to do this it conducted a comprehensive review of the literature and consulted extensively with geriatricians, researchers, rehabilitation providers and referrers. Through this research and consultation with experts it has been able to:
- delineate clearer definitions for inpatient geriatric rehab
- specify patient characteristics for geriatric rehab
- define program components for geriatric rehab
- compile an inventory of inpatient rehab programs for geriatric/medically complex patients
- develop an inpatient rehab triage guideline for geriatric patients

Dedicated geriatric rehab has been distinguished by the fact that its services are provided by an interdisciplinary rehab team with expertise in geriatric assessment and treatment. Geriatric rehabilitation includes assessment and treatment of the geriatric syndromes- including instability or falls, isolation or depression, cognitive impairment including delirium and dementia, incontinence, immobility, polypharmacy and inadequate nutrition.

In other rehab programs that accept geriatric patients the interdisciplinary team may or may not have the necessary expertise in geriatric assessment and treatment. However, it is now being suggested that these programs will need to at least have a physician with geriatric expertise and expertise in multi-system issues to be considered as a program providing geriatric rehabilitation. If geriatric expertise is to be available in all rehab programs, leadership is required to develop opportunities for education and training of rehab staff.

The literature did not provide definitive guidance regarding evidence-based best practices around ideal staffing levels. Consequently, no suggestions regarding staffing levels are put forward here. There remains a need to identify the ideal staffing levels for dedicated and mixed programs or the critical mass needed on mixed units to enable medical and/or allied health staff to develop and maintain clinical expertise in geriatric care.

These findings and discussions among the Task Group have lead to the following recommendations for next steps.

6.0 RECOMMENDATIONS

The Coordinating Council of the GTA Rehab Network has reviewed the findings summarized in this report and endorsed the recommendations below. As the GTA Rehab Network moves forward with work in the area of geriatric rehabilitation, it will continue to monitor and take into consideration new evidence in geriatric rehabilitation as it emerges as well as other initiatives that are embarked upon in this area.

6.1 Program Considerations

- Following the evaluation of the triage guidelines, the results are to be reviewed and analyzed to determine their effectiveness as a tool for referring patients to inpatient geriatric rehab. The entire evaluation process will take approximately three months to trial the guidelines, analyze the data and incorporate revisions into the finalized tool. Subsequently, training in the use of the Inpatient Rehab Triage Guidelines for Geriatric Patients should be provided for clinicians in acute care and rehab hospitals.

- It is recommended that all organizations that provide geriatric inpatient rehabilitation review the definitions and the distinctive features of the various programs (e.g. Geriatric Assessment Unit versus Geriatric Assessment and Treatment Unit) to ensure that the programming offered and program names used are consistent with the definitions that have been developed. This includes an assessment of the skill sets among nursing, allied health and medical staff to ensure that the degree of geriatric expertise that is available conforms to the recommendations in the definitions framework.

- It is recommended that the definitions work proceed with developing definitions for geriatric rehab in outpatient and community-based settings. Upon completion of the work, a strategy will be developed with the Rehab Definitions Advisory Committee to incorporate use of population-specific definitions across Network member organizations.

- The definitions that have been developed for inpatient geriatric rehab, including the triage guidelines, can be used to inform the development of a common rehab referral form as part of GTA Rehab Network's overall strategy to streamline referral processes. The common rehab referral form will include population-specific inserts with a view to exploring and leveraging e-health opportunities to incorporate geriatric and other rehab referrals as part of a central model for post-acute referrals.

- Each of the five Toronto area Local Health Integrated Networks have identified seniors as a priority. The Toronto Central and Central West Local Health Integration Networks have identified seniors *and* rehabilitation as key priorities in their current Integrated Health Service Plans while others see rehab as an enabler to their priorities. As a result, there may be opportunities to leverage and apply findings from this initiative to geriatric-focused LHIN activities.

6.2 Education Considerations

At present, geriatric expertise is situated within dedicated geriatric rehab programs. However, not all older rehab candidates are necessarily referred to these programs as some rehab patients may be best served in rehab programs with expertise in particular diagnostic conditions (e.g. stroke). Recognizing that almost half of rehab inpatients currently are over 74 years of age[20], it is anticipated that the proportion of older patients referred for rehab with greater medical complexity will likely increase in future. It is therefore recommended that the GTA Rehab Network collaborate with the RGP of Toronto to develop an

[20] Canadian Institute for Health Information. *Inpatient Rehabilitation in Canada, 2003-2004. Special Topic: A Look at the Older Population.* (2005)

education plan and recommendations for implementation to increase knowledge in and use of the principles of geriatric care across all rehab programs. The education plan and strategy will be developed within the next three months.

6.3 Funding Considerations

In light of the current work that is being done around the implementation and evaluation of a new inpatient rehab funding formula, monitoring of the new formula is recommended to ensure that it takes into consideration the unique needs of geriatric rehab patients.

7.0 CONCLUSION

The GTA Rehab Network has prioritized geriatric rehabilitation as an area of focus in response to the findings of its 2006 ALC survey and feedback received from its stakeholders involved in the referral of geriatric patients for inpatient rehabilitation. The goal of the first phase of the geriatric initiative was to increase clarity for referrers about the inpatient rehab options available to geriatric patients. Drawing on the expertise of geriatric specialists from acute care and rehab across the province and a review of the literature, definitions have been developed to standardize the terminology used to classify the services available; describe geriatric rehab services provided on mixed units, dedicated geriatric units and in low tolerance rehab programs; and delineate differential criteria for each type of service. The GTA Rehab Network will continue in its efforts to improve access to geriatric rehab and expertise in geriatric care across the rehab continuum through its work on establishing rehab program definitions and other system initiatives.

8.0 APPENDICES

Appendix A: Geriatric Rehab/Medically Complex Task Group Members

Dr. Mark Bayley	Medical Director, Neuro Rehab Program, Toronto Rehab (*Chair*)
Carol Anderson	Director of Complex Continuing Care, Geriatrics and Rehabilitation Services, Lakeridge Health
Judy Bonham	Patient Care Manager, Medically Complex Unit, Bridgepoint Health
Tanya Diamond	Acting Director, Complex Continuing Care, York Central Hospital
Alexis Dishaw	Director, Innovation and Special Projects, Toronto Grace Health Centre
Dr. John Flannery	Medical Director, Musculoskeletal Rehabilitation, Toronto Rehab
James Fox	Director Patient Care, Providence Healthcare
Dr. Barbara Liu	Program Director, Regional Geriatric Program of Toronto
Sandra Dickau	Patient Care Manager, Transitional Care Unit, St. Joseph's Health Centre
Paul Man-Son-Hing	Manager of Professional Practice, Toronto East General Hospital
Kim Kohlberger	Program Leader, Rehabilitation and Geriatrics, Halton Health Care Services
Donna Renzetti	Acting Director, Program Operations, West Park Healthcare Centre
Sandra Tully	Acute Care Nurse Practitioner, Family Practice/Geriatrics University Health Network
Kathy Sullivan	Consultant, GTA Rehab Network
Dr. Shelly Veinish	Medical Director, GATU, Baycrest
Laurence Wolfson	Director, Mental Health, Addictions and Continuing Care, William Osler Health Centre
Charlie Yang	Case Manager, Nephrology/Diabetes Care, St. Michael's Hospital
Charissa Levy	Executive Director, GTA Rehab Network
Sue Balogh	Project Coordinator/Planner GTA Rehab Network

Appendix B: Terms Of Reference: Rehab Definitions Task Group

Background

The GTA Rehab Network's Rehab Definitions Task Group developed a Rehab Definition Conceptual Framework to describe and clarify the core categories of rehabilitation across the rehab continuum. Further to the work of the Task Group, the framework is being expanded to include evidence-based (where available) population-specific definitions within each rehab category. In the absence of literature, the definitions will be based on current clinical standards of practice. An initial focus of this work is geriatric rehab.

Stakeholders report that there is a lack of clarity in making rehab referral decisions for geriatric patients, including those deemed "medically complex". Rehab options may include geriatric rehab programs; rehab programs that accept geriatric rehab patients, including 'complex medical' rehab programs; and complex continuing care programs that provide low tolerance long duration geriatric rehab. Clear definitions and criteria for the terms used to describe these patients (e.g. "geriatric", "frail" and "medically complex") as well as greater clarity to differentiate between and across various programs that provide rehabilitation to geriatric patients are needed in order to reduce difficulties and delays in accessing inpatient rehabilitation.

Mandate

Recognizing that delays in accessing rehabilitation can result from an interplay among various factors (e.g. capacity, staffing/equipment resource requirements, referral processes), the mandate of the committee is to contribute to the reduction of the number of patients in ALC waiting for geriatric rehabilitation services by developing clear definitions and criteria for the terms "geriatric," "frail" and "medically complex" and defining the key components of rehabilitation required for these patients. Doing so will increase clarity for referrers about where to refer geriatric patients for rehab. Through this initiative, the issues that affect access to geriatric rehab for these patients will also be identified and possible solutions proposed. The first phase of committee work will focus on inpatient rehabilitation.

Accountability

The Geriatric Rehab/Medically Complex Task Group is accountable to the Rehab Definitions Advisory Committee, an advisory committee that is accountable to the Coordinating Council of the GTA Rehab Network.

Membership

Membership on the committee includes Network members within the GTA LHIN boundaries from acute care, rehab centers, complex continuing care and the Regional Geriatric Program of Toronto.

Length of Term

Membership on the committee for the first phase of work on inpatient rehabilitation is for a period of 4 months or until the activities are completed to the satisfaction of the committee.

Chair of the Committee

Dr. Mark Bayley

Frequency of Meetings

Meetings will be held on a monthly basis, but may occur more frequently or consultation may be conducted via other means (telephone/email) to achieve the deliverables within the projected timelines.

Budget and Resources

The GTA Rehab Network is contracting with an external consultant to work with the content experts identified above and lead achievement of the activities and deliverables outlined below.

Activities

- Conduct key informant interviews to identify best practices in geriatric rehab, patient characteristics and issues affecting access to rehabilitation.
- Define the key characteristics of geriatric patients who require inpatient rehabilitation.
  - This will include differentiating patients in need of specialized geriatric rehab, general rehab or services provided to geriatric patients in CCC.
- Develop a triage guideline to assist referrers in determining where to send geriatric patients for inpatient rehabilitation.
- Prepare a detailed inventory of: (1) designated geriatric rehab programs; (2) general rehab programs that accept geriatric/medically complex patients; and (3) CCC programs that provide low tolerance, long duration geriatric rehab across GTA Rehab Network members. The inventory will include admission and exclusionary criteria as well as staffing and other program resources – to be conducted by secretariat staff.
- Using the GTA Rehab Network's Rehab Definitions Framework, define the core rehab components required for the 3 program categories using evidence-based parameters and/or work completed in other jurisdictions where available. Where literature or other work does not exist, definitions will be based on current clinical standards of practice.
- Through this initiative, identify the issues that affect access to geriatric rehab and possible solutions that include but are not limited to consideration of a model for centralizing the rehab referral process while supporting the benefits of existing organizational relationships.

Deliverables

- A triage guideline with definitions that clearly describes candidates for geriatric rehab and differentiates between the 3 rehab program categories being considered (i.e., specialized geriatric rehab programs; rehab programs that accept geriatric patients; and CCC programs that provide low tolerance, long duration geriatric rehab)
- Common understanding and agreement upon the core program components of the 3 rehab program categories
- Identification of barriers to these geriatric rehab programs and proposed solutions to address these
- Recommendations to the GTA Rehab Network regarding the feasibility of a model for centralizing the geriatric rehab referral process while supporting the benefits of existing organizational relationships.
- A final report summarizing the initiative, key findings and recommendations for next steps.

Expected Outcome/Impact

- Reduction in patients in ALC awaiting geriatric rehab through improved referral practices as a result of:
  - standardized rehab definitions that provide increased clarity and consistency about the forms of physical and cognitive rehabilitation across different care settings reduces confusion for referrers and improves patient access to geriatric rehab services.
  - enhanced organizational practices to adhere to the benchmarks set out in the Network's rehab referral guidelines
  - Note: the extent to which a reduction of patients in ALC is demonstrated will also be determined by current capacity limitations.
- Increased clarity about rehab patients in need of inpatient geriatric rehabilitation or described as 'medically complex' and the rehab services available to them.
- Standardized geriatric rehab definitions and essential components of rehab programs that incorporate established evidence-based benchmarks for population-specific rehab programs to inform program planning and support performance measurement.

Appendix C: References

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Appendix D: List of Key Informants

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Appendix E: Inpatient Geriatric Rehab Program Components

Geriatric Rehabilitation

A program designed to optimize 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.[21] Geriatric rehabilitation provides evaluative, diagnostic and therapeutic interventions to restore functional ability or enhance residual functional capacity in elderly people with disabling impairments[22]

Dedicated Geriatric Rehab Units in Acute Care and Rehab Hospitals Inpatient Rehab: Suitable for individuals in need of an interdisciplinary rehab program and who also require 24-hour hospital care.	
Names Typically Used	• Geriatric Rehab • Geriatric Rehab Unit (GRU) • Geriatric Assessment & Rehab Unit (GARU)/Geriatric Assessment &Treatment Unit (GATU)
Services Provided	• The pre-existing frailty and multiple needs of older patients may necessitate a lengthier and more complex rehab process than in similarly impaired younger people. • These programs provide a moderately intensive rehab program. It is expected that geriatric rehab patients can tolerate therapy ≥ 30 minutes x 2 per day, 5 days a week. Tolerance includes participation in all activities scheduled with therapy and nursing staff.* • Rehab services are provided by an 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, Recreation Therapy and Chaplaincy/Pastoral Care. • Program provides assessment and treatment of geriatric syndromes-instability or falls, isolation or depression, cognitive impairment including delirium and dementia, incontinence, immobility, poly-pharmacy and inadequate nutrition. The key differentiating feature of geriatric rehab is that the assessment and treatment of these multi-dimensional factors are as much of the rehab focus as is the illness or injury which directly led to the most recent hospitalization. In geriatric rehab units the emphasis is on restoration of functional status.[23] • Geriatric Assessment Units (GAU), and Acute geriatric units (AGU) also provide interdisciplinary assessment and rehabilitation for older persons with complex medical, psychological and social problems. There is more emphasis on medical management in geriatric assessment units and rehab goals are usually short term. GAU/AGUs require onsite access to diagnostics in order to support their assessments.
Specialization vs. Non-Specialization	Geriatric rehab treats patients with: • 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 • These patients are typically frail, have multiple co-morbidities and functional impairment.

* See GTA Rehab Network Inpatient Triage Guidelines for Geriatric Patients.

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[23] Borrie MJ, Stolee P, Knoefel FDet al. Current best practices in geriatric rehabilitation in Canada. *Geriatr Today:Can J Geriatr Med Psychiatry* 2005: 8:148-153.

Appendix E (continued)

Dedicated Geriatric Rehab Units in Acute Care and Rehab Hospitals (continued) Inpatient Rehab: Suitable for individuals in need of an interdisciplinary rehab program and who also require 24-hour hospital care.	
Differential Criteria	• Program appropriate for patients whose pre-morbid function score is impaired. • Program is staffed by a dedicated interdisciplinary team, including a physician with expertise in the care of the elderly and who 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. Geriatric and psycho-geriatric consultation should be available. • Team holds regular team meetings/conferences to co-ordinate care. • Beds are geographically clustered. • 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. • Patients accepted with reduced motivation secondary to depression. • Patients accepted with moderate cognitive impairment • 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. 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)[24] and Geriatric Depression Scale (GDS[25]). Nutritional screening is also a necessary component.
Typical Duration	• LOS targets designated by RGP are 2 weeks for AGUs, 4-6 weeks for GATUs and 4-12 weeks for GRUs.
Key Activities/ Nature of Service	• Geriatric rehabilitation programs are suitable for individuals requiring a moderately intensive interdisciplinary rehab program. • Population-specific wellness programs that provide health education, goal setting, behaviour change principles and practices to promote health and wellbeing of the individual and secondary prevention are offered. • The use of Goal Attainment Scaling (GAS)[26] 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 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.[27]

[24] 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

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[27] 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.

Appendix E (continued)

INPATIENT GERIATRIC REHAB PROGRAM COMPONENTS (cont'd)

*Components of Comprehensive Geriatric Assessment[28]

Components	Elements	
Medical assessment	Problem list Co-morbid conditions and disease severity Medication review Nutritional status	
Assessment of functioning	Pre-morbid/baseline level of functioning in I/ADLs\ activities of daily living Instrumental activities of daily living Activity / exercise status Gait and balance Mental status (cognitive) testing	Basic
Psychological assessment	Mood / depression testing	
Social assessment	Informal support needs and assets Care resource eligibility / financial assessment	
Environmental assessment	Home safety Transportation and tele-health	

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

Appendix E (continued)

INPATIENT GERIATRIC REHAB PROGRAM COMPONENTS (continued)

Geriatric Rehabilitation

A program designed to optimize 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.[29] Geriatric rehabilitation provides evaluative, diagnostic and therapeutic interventions to restore functional ability or enhance residual functional capacity in elderly people with disabling impairments[30]

Mixed Rehab Units in Acute Care and Rehab Hospitals Inpatient Rehab: Suitable for individuals in need of an interdisciplinary rehab program who also require 24-hr. hospital care.	
Names Typically Used	• General Rehabilitation or Medical Rehabilitation
Services Provided	• 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. Tolerance includes participation in all activities scheduled with therapy and nursing staff. • An interdisciplinary team provides rehab. Core team typically includes: Physician, Nursing, Physiotherapy, Occupational Therapy, Social Work, Pharmacy, Speech-Language Pathology, Clinical Dietician, Recreation Therapy and Chaplaincy/ Pastoral Care. • Access to physician with expertise in medical complexities found in geriatric patients (e.g. polypharmacy, incontinence, falls).
Specialization vs. Non-Specialization	• Rehab providers assess/ treat a variety of diagnostic/rehab population groups. Specialization is encouraged where there is a sufficient critical mass to support the development and maintenance of clinical expertise in geriatrics at least in medical staff.
Differential Criteria	• Programs serve a variety of diagnostic population groups. • Geriatric patients who are appropriate for a mixed unit are patients whose primary diagnosis falls outside of the other rehab population groupings (e.g. MSK, Stroke) and whose premorbid functioning was mild to moderately compromised but who are able to tolerate a higher intensity rehab program (i.e. ≥ 120 minutes daily, 5 days per week)* • Designated interdisciplinary team, including at least a physician with experience in the medical complexities found in geriatric patients. • Coordinated team approach with regular team meetings/conferences. • Geographically clustered beds • Expectation is that patients will either be discharged home or to their preferred accommodation in the community or to a more specialized rehabilitation program.
Typical Duration	• 2-8 weeks; some rehab units located in acute care hospitals have 3-14 day length of stay.
Key Activities/ Nature of Service	• Program provides intensive interdisciplinary rehab program for geriatric patients. • Disease or population-specific wellness programs that provide health education, goal setting, behaviour change principles and practices to promote health and wellbeing of the individual and secondary prevention may be offered.

* See GTA Rehab Network Inpatient Triage Guidelines for Geriatric Patients.

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

[30] 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.

Appendix E (continued)

INPATIENT GERIATRIC REHAB PROGRAM COMPONENTS (continued)

Geriatric Rehabilitation

A program designed to optimize 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.[31] Geriatric rehabilitation provides evaluative, diagnostic and therapeutic interventions to restore functional ability or enhance residual functional capacity in elderly people with disabling impairments[32]

Low Tolerance Long Duration Rehab in CCC and Rehab Hospitals LTLD Rehab: 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 low intensity, long duration rehab	
Names Typically Used	• Geriatric Activation Program; Complex Medical; Functional Enhancement
Services Provided	• Low to moderately intensive rehab program • Expectation is that patients can tolerate a minimum of 20 minutes of therapeutic activity per day. Tolerance includes participation in all activities scheduled with therapy and nursing staff. • An interdisciplinary team provides rehab. • Core team typically includes: Physician, Nursing, Physiotherapy, Occupational Therapy, Social Work, Pharmacy Consultation Speech-Language Pathology, Clinical Dietician, Recreation Therapy, Chaplaincy • Access to physician with expertise in medical complexities found in geriatric patients (e.g. polypharmacy, incontinence, falls).
Specialization vs. Non-Specialization	• 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 • Specialization is encouraged where there is a sufficient critical mass to support the development and maintenance of clinical expertise in geriatrics at least in medical staff and the acquisition of special equipment and other resources required to treat the geriatric group.
Differential Criteria	• Program appropriate for patients whose pre-morbid functioning was impaired and who require a slower-paced rehab program for a longer duration to maximize rehab potential. • Dedicated interdisciplinary team, including at least a physician with specialization in the medical complexities found in geriatric patients. • Coordinated team approach with regular team meetings/conferences. • Geographically clustered beds • The expectation is that patients will return to home or a community residential setting following LTLD rehab. • Patients may be exempt from co-payment when located in CCC while the realistic goal for them remains returning to the community.
Typical Duration	• Typical duration is usually around 3-6 months.
Key Activities/ Nature of Service	• LTLD rehab is typically offered in complex continuing care. • LTLD rehab is suitable for individuals in need of an interdisciplinary rehab program, who require an extended period of rehab to maximize recovery. • Disease or population-specific wellness programs that provide health education, goal setting, behaviour change principles and practices to promote health and wellbeing of the individual and secondary prevention may be offered.

• See GTA Rehab Network Inpatient Triage Guidelines for Geriatric Patients.

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

[32] 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.

Appendix F: Rehab Program Inventory

INPATIENT REHAB PROGRAMS FOR GERIATRIC/MEDICALLY COMPLEX PATIENTS [33]

Geriatric Rehabilitation

A program designed to optimize 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. Geriatric rehabilitation provides evaluative, diagnostic and therapeutic interventions to restore functional ability or enhance residual functional capacity in elderly people with disabling impairments[34]

SECTION I: DEDICATED GERIATRIC ASSESSMENT/REHAB PROGRAMS

Dedicated Geriatric Assessment/Rehab: also known as Geriatric Rehab Units (GRU), Geriatric Assessment and Treatment Units (GATU) and Geriatric Assessment and Rehab Units (GARU)

- These programs provide a moderately intensive rehab program provided by an interdisciplinary rehab team with expertise in geriatric assessment and treatment.
- Rehabilitation includes assessment and treatment of geriatric syndromes-instability or falls, isolation or depression, cognitive impairment including delirium and dementia, incontinence, immobility, poly-pharmacy and inadequate nutrition. The key differentiating feature of geriatric rehab is that the assessment and treatment of these multi-dimensional factors are as much of the rehab focus as is the illness or injury which directly led to the most recent hospitalization. In geriatric rehab units the emphasis is on restoration of functional status.
- Geriatric rehab treats patients who are typically frail, have multiple co-morbidities and functional impairment with complex underlying medical and functional problems, unexplained pre-morbid problems coping at home and/or an insult or complicated course in hospital such as delirium, pneumonia or a fracture.
- Typical length of stay based on the Toronto Regional Geriatric Program guidelines for GATUs/GARU is 4-6 weeks and 4-12 weeks for GRU.
- This type of rehab may be located in designated rehab beds or complex continuing care beds.[35]

[33] As per scan of programs in GTA Rehab Network's *Rehab Finder*.
[34] 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.
[35] Beds located in complex continuing care will be denoted as (CCC) in the 'No. of Beds' column.

Dedicated Geriatric Assessment/Rehab programs (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
Baycrest	Geriatric Assessment & Treatment Unit (GATU)	8 beds	Specialized geriatric program for patients who may have one or more of the following: non-acute multiple and/or complex medical problems; mild to moderate cognitive impairment; recent functional decline. • For Geriatric and General pop. • 65 years and older • Comprehensive Geriatric Assessment is provided to assess and plan treatment for geriatric syndromes.	People with the following conditions are not appropriate for admission: acute/unstable medical illness; severe cognitive impairment; identified terminal illness as primary presenting problem; inability to return to community or referring facility; requiring immediate placement in long term care; require extensive testing using resources and equipment not readily accessible at Baycrest Centre may be redirected to an in-patient program at an acute care hospital within the RGP	<u>Staffing for 32 bed unit: 24 rehab + 8 GATU:</u> RN: 3 (day); 2(evening); 1 (night) RPN: 3 (day); 2 (evening); 1 (night) Geriatrician: 1.0 Attending Physician: 1.0 PT: 2.25 PTA: 1.5 OT: 2.5 OTA: 0.5 Recreation Therapy 1.0 SW 0.8 SLP .83 (shared with OPD) Dietician 0.7 (shared) Pharmacy 0.4
Baycrest	Inpatient Geriatric Rehab	8 General Geriatric beds 8 MSK Geriatric beds 8 Neuro / Stroke Geriatric beds	• For patients 55+ • Populations served: Chronic Pain, Geriatric, MSK, Neuro & Stroke • Diagnosis/Conditions Include: a) Geriatric Rehab: Vascular (CHF/CAD), Post Surgery (Non MSK or Neurological), Infection (Pneumonia/Sepsis including Central lines), Generalized Failure to Thrive (secondary to geriatric giants such as incontinence, cognitive impairment, depression, falls, malnutrition) and Chronic Pain management. b) Musculoskeletal: Fracture (hip, knee, shoulder, ankle, vertebra, pelvic). Joint replacement (hip, knee). Arthritis (rheumatoid, osteo). Must be at least partial weight bearing for post-op ortho patients c) Neurologic: Thrombo-embolic Stroke, Intracranial Hemorrhage, Parkinson's Disease, MS, Tumor and TBI/ABI. • Must demonstrate capacity for learning (able to follow simple 2 step instructions), retention and	• Wandering • Cannot accommodate a primary diagnosis of traumatic spinal cord injury; need for dialysis; decubitus ulcers that prohibit active rehabilitation; amputees requiring prosthetic fitting and training; psychiatric problems interfering with rehabilitation treatment; or primary respiratory ailment. • Cognitive impairment that impairs learning/carryover • Safety risk to self/others • Presence of TB or other infectious respiratory illness	

Dedicated Geriatric Assessment/Rehab programs (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
			carry-over of information presented in the therapeutic program • Able to tolerate 30 min. of rehab twice per day; sitting tolerance 30 min. • Anticipated LOS <90 days; discharge plan must be in place		
Credit Valley Hospital	Geriatric Assessment Unit	6 rehab beds located on 40 bed rehab unit	For patients 65+ who require assessment of complex medical/comorbid conditions and reactivation from a multidisciplinary rehab team to improve functioning. Patients typically present with: • Complex medical and psychosocial issues • Unexplained decline in health and/or function • Loss of capacity for independent living • Able to participate in 30 minutes therapeutic activity • Able to demonstrate reasonable level of compliance • Length of stay may vary 2-6 weeks with average length of stay of approximately 4 weeks.	• Uncontrolled aggressive behaviour to self/others • TPN is not supported. As well, patients who suffer from disabling diseases which are not amenable to therapy from the multidisciplinary team and are impairing the patient's ability to function and participate in treatment e.g. severe dementia	<u>Staffing is shared across 40 bed unit:</u> RN/Pt ratio: 1:4 or 5 (day); 1: 6-7 (evening); 1:10 (night) No RPN Physician: 1 Geriatrician OT: 0.4 PT: 0.7 PTA: 0.2 Therapeutic Recreationist: 0.3 SW: 2.0 SLP: On consultation as needed Psychologist: Assesses approx. half of geriatric patients
Lakeridge Health	Geriatric Assessment & Rehab Unit	32 bed unit (CCC): 25-27 beds: Geriatric rehab 4-6 beds: LTLD (primarily stroke patients) 1-2 beds: GATU	Specialized geriatric service for frail older persons (75+) with functional impairment secondary to: • general medical de-conditioning secondary to multiple pathologies, both medical and surgical; • musculoskeletal problems such as joint surgery, replacement or fracture; • neurological disorders such as CVA, Parkinson's, MS. • vascular conditions such as CHR, CAD • generalized failure to thrive (secondary to geriatric giants such as incontinence, cognitive impairment, depression, falls, malnutrition). • Must demonstrate capacity for learning and retention • Rehab Tolerance: approx.20 min. at least 3x per	• Wandering • Cognitive impairment that impedes learning and retention • Safety risk to self/others • Infectious illnesses/diseases that require isolation • Primary psychiatric and psychogeriatric disorders • Activity limited to bed rest	<u>Staffing shared across 32 bed unit:</u> Physiatrist: 0.50 (with training in geriatric rehab) RN: 2 + charge RN (day); 2 (evening); 1 (night) (Nurse /Patient ratio: 1:4 (day); 1:5 (evening); 1:10 (night)) Acute Care Nurse Practitioner: 1.0 RPN: 6 (day); 4 (evening); 2 (night) PT: 2.0 OT: 2.0 OTA/PTA: 2.0

Dedicated Geriatric Assessment/Rehab programs (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
			week or higher as patient is able to tolerate		SW: 1 SLP: 0.25 Dietician: 0.5 Pharmacist: Consult basis Chaplain: Consult basis Neuropsychologist: Consult basis
Providence Healthcare	Inpatient Specialized Geriatrics Program	23 Geriatric rehab beds 22 GATU beds (CCC)	• For patients with complex medical and psychosocial problems or recent unexplained breakdown in health or function • Patients who have a medical or surgical diagnosis from which they are recovering. Patients are frail elderly with several comorbid conditions who will benefit from an inpatient rehabilitation program prior to returning to community living. • Specialize in older adults but accept patients 18+ • Understand and retain instructions • Rehab Tolerance 30-40 minutes • Discharge plan in place • Patients who require assessment of geriatric syndromes are admitted to the GATU beds with an average length of stay of 4-6 weeks.	• Non-weight-bearing status. (May be admitted to CCC while NWB) • Aggressive behaviour • Wandering • Unable to accommodate patients with impairment from a brain injury, an acute psychiatric condition • Active TB	<u>Staffing is shared between Geriatric Rehab and GATU:</u> RN: 3 (day); 3 (evening), 2 (night) RPN: 6 (day); 4 (evening); 2 (night) Physician: Medical director of GRU/GATU has experience and interest in geriatrics. Geriatric and psychogeriatric consultation available. PT: 2.5 OT: 2.5 PTA/OTA: 2 Rec. Therapists: 0.55 Rec. Assistant: 0.7 SW: 0.8 SLP: on consult Ward Aid: 0.5 Clinical leader: 1 Dietician:0.3 Pharmacy: 0.6
Rouge Valley Health System	Inpatient Geriatric Assessment and Treatment Unit – Centenary	17 beds (CCC)	Services provided by interdisciplinary team members include comprehensive geriatric assessment and intervention for frail elderly patients who have sustained significant illness or injury. Assessment is primary focus of admission. • Primary referral sources are within Rouge Valley	• Wandering unless family able to provide sitter • Significant cognitive impairment preventing adequate assessments and/or interventions • Acute psychiatric episodes including	<u>Staffing is shared across 54 bed unit:</u> RN: 5 (day) 4 (evening) 2 (night) RPN: 5 (day) 4 (evening) 3 (night) Geriatrician: 1

Dedicated Geriatric Assessment/Rehab programs (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
	site		Health System. • The average length of stay is 3–6 weeks. • Acute medical condition is stable • Primarily frail elderly patients, 65 years or older, who have sustained significant illness or injury and who may be suffering from complex medical and/or functional conditions. • Diagnoses include: General medical and geriatric conditions including multiple pathologies, polypharmacy, high risk for re-admission, and symptom complexities, e.g., incontinence, dementia, delirium, etc. • Patient must be able to weight bear as tolerated but may require supervision or light assistance • Patient must demonstrate suitable cognition to participate in three 15-minute physiotherapy sessions and four 15-minute occupational therapy sessions per week. • Patient must demonstrate: ability and willingness to participate in physio and occupational therapy; - sitting tolerance of not less than 30 minutes; - ability to remain alert; enough memory and recall to focus attention for short periods in order to follow instructions, learn, and retain information. • Firm and agreed upon discharge plan is required as part of the application for admission to the GATU Program. This is subject to change in accordance with patients progress/status.	altered thought processes • Significant attention, judgment, alertness or orientation deficits that may interfere with safe participation in the program or the safety of self and/or others on the unit. • Aggressive behaviors, (physical or verbal) that pose safety risks to themselves and/or others. Symptomatic drug or alcohol withdrawal posing risk to self or others. • Patient (or substitute decision maker) refuses or is unwilling to be admitted to the program • Patient is unable or refuses to participate in reactivation or other rehabilitative therapy sessions • Patient has entered an 'acute' palliative stage, requires ventilator support or TPN. • Patient requires a daily intensive or long term rehabilitation program	Other Physician: 3 Part-time GPs PT: 1.1 OT: 1.2 PTA/OTA: 2.0 Recreational Therapy: 1.0 SW: 1.0 Clinical Pharmacy: 0.3 Consultation from nutrition, psychology, psychiatry, neurology and other medical specialties is available.
Toronto Rehab	Inpatient Geriatric Rehab	28 beds (16 beds for specialized geriatric rehab; 12 who	For patients 65+ whose main conditions may include: • Falls, with or without injury • Deconditioning post-operatively • Cardiac • Respiratory	• Non-weight bearing • Wandering • Fluctuating levels of consciousness, acute/unresolved delirium, acute psychiatric episodes, complex behavioural issues, actively	RN: 5 days (4 weekends), 3 evenings, 2 nights RPN:5 days PT: 3; PTA: 0.5 Physician: Family Physician with specialized training in geriatric care.

Dedicated Geriatric Assessment/Rehab programs (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
		require hemo-dialysis)	• Stroke or other neurological conditions • Orthopaedic conditions • Medically complex conditions • Able to participate in ADLs plus two 30 minute therapy sessions per day • Hemodialysis patients need to have an approved outpatient hemodialysis treatment spot in the community • Discussion re: discharge plan initiated	progressing malignant conditions • Impairment from traumatic brain injury requiring neuro-cognitive interventions • Clients with respiratory symptoms that do not pass admission screening; respiratory illnesses requiring strict isolation (e.g.. active pulmonary tuberculosis). • Constant nursing care required	OT: 3: OTA: 0.5 SLP: 0.5 SW: 2 Pharmacist: 0.5 Dietician: 0.75 Recreation Therapy: 0.5
Toronto Rehab	Inpatient Geriatric Psychiatric Unit	20 beds	For older individuals (65+) with dementia and associated complex behaviours • Occasionally younger patients with memory problems are admitted • Patients who cannot be cared for at home or in long term care due to dementia related complex behaviours May have restriction in their mobility May have multiple cormorbidities Require 24 hour care Require daily physiotherapy, occupational therapy, speech language pathology, social work and therapeutic Recreation interventions as well as clinical pharmacy and clinical nutrition assessments. • Patients expected to transition back to LTC, retirement home or home after completion on rehab Occasionally where clinically indicated, patient admitted from home will be placed into long term care facility • Length of stay is 6-8 weeks with longer stays requiring extension of leave from the Ministry of Health and long term care so as not to jeopardize their continued residence at the home facility.	• Major psychiatric conditions • Non-dementia associated behaviours • Contagious/infectious diseases	RN: 3 (day); 2 (evening); 1 (night) = 8.4 FTE RPN: 3 (day); 3 (evening); 2 (night) = 11.2 Physician – 1 attending physician and 2 Psychiatrists with specialization in psychogeriatric care. Physiatrist: 0 PT: 0.50 PTA: 0.50 OT: 1.0 OTA: 0.50 SLP: 0.50 SW: 1.5 Therapeutic Recreation: 1.0 Dietician: 0.40 Pharmacist: 0.50 Psychology/Neuropsychology: 0

SECTION II: GERIATRIC/MEDICALLY COMPLEX REHAB ON MIXED UNITS

Geriatric/Medically Complex Rehab on Mixed Units: also known as General or Medical Rehab

- These programs provide an intensive rehab program by an interdisciplinary rehab team.
- Although rehab providers assess/treat a variety of diagnostic/rehab population groups, specialization is encouraged where there is a sufficient critical mass to support the development and maintenance of clinical expertise in geriatrics and multi-system issues at least in the medical staff.
- Geriatric patients who are appropriate for a mixed unit are patients whose primary diagnosis falls outside of the other rehab population groupings (e.g. MSK, Stroke) and whose premorbid functioning was mild to moderately compromised.
- Typical length of stay is 2-8 weeks; some rehab units located in acute care hospitals have a 3-14 day length of stay.
- This type of rehab is typically located in designated rehab beds in community hospitals

Mixed Rehab Units that accept geriatric patients (External Referrals)

Organi-zation	Name of Program	No. of Beds	Admission Criteria	Exclusion Criteria	Staffing (FTE)
Markham Stouffville Hospital	General Inpatient Rehab Program	16 beds	• For adult patients (19+) • Primarily for ortho and neuro conditions. • Must be at least 50% weight-bearing • Able to follow instructions and demonstrate new learning • Rehab Tolerance: 30 min, 3x per week	• Do not accept patients who require ventilation, dialysis. • Will not accept patients with a high level complete spinal cord lesion (i.e. T-8 or above) or an acute psychiatric illness • Aggressive patients	RN/RPN & PT/OT staffing shared across 16 rehab beds and 12 ALC beds RN Weekdays: 4 (day); 2 (evening); 2 (night) RN Weekends: 2 (day); 2 (evening); 2 (night) RPN Weekdays: 2 (day); 2 (evening); 1 (night) RPN Weekends: 3 (day); 2 (evening) 1 (night) Physician: 1 GP for rehab pts PT: 1.8 PTA: 1.0 OT: 1.6 SLP: 0.83 (covers outpatient. Video Fluoroscopy too) SW: 0.8 Therapeutic Recreation: 1.0 (covers multiple areas) Dietician: 0.7 (covers multiple areas) Pharmacist: 0.3

Mixed Rehab Units that accept geriatric patients (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
Rouge Valley Health System	Inpatient General Rehab	32 beds (Centenary site) 8 beds (Ajax-Pickering site)	High intensity general rehabilitation program services a variety of MSK and neurological conditions and/or injuries including hip fractures, joint replacements, amputations, stroke, deconditioning from surgical and medical conditions. The programs' interdisciplinary team approach is targeted at achieving defined, measurable and time-limited rehabilitation goals and returning patients to the community as independently and safely as possible. • Patient must demonstrate ability and willingness to participate in a structured, goal-focused rehab program • Patients must require at least 2 therapeutic services • Minimum sitting tolerance ≥ 60 minutes • Minimum of 2 x 20 minutes of daily therapeutic interventions (up to 5x weekly) • Discharge plan initiated and documented • Patient's disability will likely improve by short-term rehab in the expected LOS guidelines • LOS (MSK/General Medical/Surgical: up to 14 days • LOS (Neurological/COPD/Amputee: up to approximately 28 days)	• Patients requiring slow stream rehab, or specialty expertise, e.g., spinal cord injury, intense cognitive rehab / behaviour management, vocational retraining) • Need for daily intensive rehab services with multiple therapeutic interventions over a prolonged period (i.e. long term rehab)	Centenary Site: (32 beds) RN: 2 (day); 2 (evening); 2 (night) RPN: 2 (day); 2 (evening); 1 (night) Physician: 2 GPS PT: 2.5; PTA: 1 OT/OTA/PTA: 1.5 SLP: 0.5 SW: 0.8 Dietician, Pharmacist on consultation basis Ajax Pickering Site: Staffing shared across 18 bed unit (8 rehab beds, 10 Functional Enhancement beds in CCC). Rehab pts. Receive rehab on daily basis; pts on Functional Enhancement beds receive rehab 2x/week) RN: 2 (day); 1 (evening); 1 (night) RPN: 1 (day); 2 (evening); 1 (night) Physician: 1 GP PT: 1.0; OTA/PTA: 1.5 OT: 1.0 SW: 0.5 SLP, Dietician, Pharmacist on consultation basis.
William Osler Health	Inpatient MSK/Neuro /Stroke General Rehab	30 beds	For adult patients (and geriatric) in need of : • Musculoskeletal (elective knees/hips, fractures) • Neuro (strokes, multiple sclerosis, neuropathies) • General (geriatric, reconditioning/strengthening)	• Wandering • No complex medical needs such as dialysis, chemotherapy, wound care management (ie. VAC systems), enteral feeding, TPN	RN: 3 (day); 3 (evening); 2 (night) RPN: 3 (day); 2 (evening); 1 (night) Physician (GPs): 3 Physiatrist: 1 PT: 3 PTA: 2 OT: 3

Mixed Rehab Units that accept geriatric patients (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
			• Partial to full weight bearing status • Rehab Tolerance: minimum 30-min rehab sessions twice per day	• Unable to accommodate acute psychiatric episodes, ABI, aggressive behaviour, isolation needs.	OTA: 1 SLP: 1 SW: 0.5 D/C Planner: 0.5 Therapeutic Recreation: 1 Dietician 0.5 Pharmacist: 1.0
York Central Hospital	General Inpatient Rehab	32 bed unit: 17 beds for general rehab; 15 beds for Integrated Stroke Unit (5 acute care, 5 rehab, 5 CCC beds)	Typically for adult pts for stroke, orthopaedic or general rehab. (Average age on unit is 72 although younger adults will also be accepted) • Adults 18 years of age or older • Medically and surgically stable • Demonstrates motivation to improve and willingness to participate in the program i.e. attending dining room for all 3 meals, presence in gym twice per day • Clearly defined rehabilitation goals and the potential to achieve them within a specified time • Has clear and definite discharge arrangements/destination in place	• Any medical condition that requires further diagnostic investigations • Behavioral disturbances i.e. wandering and/or aggression • Cognitive impairment that affects ability to follow direction	Staffing shared across a 32-bed unit. RN: 3 (day); 2 (evening); 2 (night) RPN: 4 (day); 3 (evening); 1 (night) Physician: 12 GPs Physiatrist: 1 Allied health staffing is shared across units and information specific to the inpatient rehab program is not available.

Mixed Rehab Units that accept geriatric patients (Internal Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
Humber River Regional Hospital	Medical Inpatient Rehab Program	6 beds – medical rehab 12 beds – ortho rehab (Situated on 32 bed unit 14 = Neuro Assessment & Treatment Unit)	• General rehab: Mostly patients with Stroke > 65yrs • Ortho rehab: primarily for elective hip/knee replacement • Patients must demonstrate ability to follow instructions and participate in program; • Cooperative with short term goals • Discharge plan established	• Wandering • Significant Cognitive impairment • Behavioural issues • Patients requiring in room isolation	<u>Staffing for 32 bed unit:</u> RN/pt =: 1:5 (day); 1:6 (evening); 1:10 (night) RPN/pt = same as above 1 Physician for rehab PT: 2.5 PTA/OTA: 2 OT: 2 SLP: on consult SW: 0.5 Dietician: 0.5 Pharmacist: 0.5 Neurologist: 1 (On consultation basis) D/C Care Coordinator: 1
North York General	General Inpatient Rehab	15 beds	Adult and geriatric patients accepted with the following conditions: • MSK • Neuro • Cardiac • Respiratory • Able to follow instructions • Rehab Tolerance: minimum 20 minutes with potential for improvement	• Wandering • Behavioural problems • Active infectious illnesses	<u>Staffing is shared across a 30 bed unit: 15 beds rehab; 15 beds for patients waiting for LTC or longer term, external rehab program.</u> Physicians: 3 RN: 3 (day); 3 (evening); 2 (night) RPN: 3 (day); 3 (evening); 1 (night) PT: 2 PTA: 1 OT: 1.4 OTA: 1 Speech Pathologist: 0.3 Recreationist: 1 Social Worker: 1 Dietician: 0.3 Pharmacist Aide: 0.5 Unit Coordinator: 1.0 Unit Administrator: 1.0
Sunnybrook Health Sciences Centre	General Inpatient Short-Stay	8 beds	Serves almost 100% geriatric patients (patients over 65). Diagnoses not specified. • Must be able to sit up unsupported for 1 hour	• Wandering • Aggressive, agitated, combative behaviour • Patients requiring isolation	<u>Staffing shared across 36 bed unit:</u> Physician: 2 attending and many residents Physiatrist: 0 RN: 9(day); 7(evening); 5(night) RPN: 0

Mixed Rehab Units that accept geriatric patients (Internal Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
			• Able to follow visual and/or verbal commands • Rehab Tolerance: Must be able to tolerate 2 hours of therapy 5 days per week • Confirmed discharge destination (LOS = 10 days)	• patients going to nursing homes, patients on intravenous for hydration and patients on TPN	PT: 2; PTA: 0.25 OT: 1.8; OTA: 0 Speech: 1.5 Social Work: 2 Therapeutic Rec: 0.25 Dietician: 0.3 Pharmacist: 1.0 Neuro/Psych: 0
St. Joseph's Health Centre	General Inpatient Rehab (Note: External referrals accepted when beds are available)	10 beds	For adults patients, including Geriatric with the following conditions: • Musculoskeletal- joint replacements, fractures, soft tissue injuries • Neurology- CVA and other conditions • Cardio-Respiratory- post myocardial infarction, chronic obstructive pulmonary disease exacerbation, pneumonia • General medicine and surgery diagnoses • Function needs to be sufficient to enable discharge to a pre-determined community setting within 5-14 days	• Wandering • Socially inappropriate behaviours • Cognitive impairment limiting participation in therapy • Infectious diseases	<u>Staffing for RN/RPN per 12 hour shift</u> RN: 1 (day); 0 (night) RPN: 1 (day); 2 (night) Physician: 1 PT: 1.0 PTA/OTA: 1.0 OT: 1.0 (Coverage for PT, OT, OTA above pertains to weekdays. On weekends, there is 1 OT & 1 PTA/OTA on one day and 1 PT & 1 OTA/PTA on the other day) SLP: 0 SW: 0.6 Clinical Care Coordinator: 0.5
Toronto East General Hospital	Short Term Inpatient Rehab	13 beds – general medical rehab	For TEGH patients who require rehabilitation due to: • Any condition typically managed on one of TEGH's acute, adult, physical medicine units are welcome. However, the rehab. Population primarily consists of joint replacements, general surgery and medical diagnoses, fractures, and falls. • Achieve functional goals in 4 -30 days • Patients typically older • Sufficient cognitive abilities to permit participation and progress in rehabilitation.	• Wandering • Isolation requirements • Uncooperative behaviour	<u>Staffing shared across 21 beds (General Medicine acute beds and rehab beds)</u> RN: 1 (day); 1 (evening); 1 (night) RPN: 3 (day); 2 (evening); 1 (night) Physician (GP): 1 PT: 1.0 PTA/OTA: 1.0 OT: 1.0 SLP: 0.2 SW: 1.0 Dietician: 0.2 Pharmacist (?FTE; shared)

Mixed Rehab Units that address "Medically Complex" rehab needs (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
Bridgepoint Health	Medical Rehabilitation Program	16 beds	For Adult patients (18+) who require: • Post-operative convalescence and rehabilitation. • Medical conditions may include: cardiac, respiratory, oncology, transplants, GI, etc. • Must have rehab potential and able to follow 2 step commands and retain new learning. Must have some insight and be able to demonstrate that there is carryover • Rehab Tolerance: Able to participate 5 times per week for a minimum of 2-3 therapy sessions (1 1/2 - 2 hours)/ day Motivated or where motivation is lacking, the underlying etiology is addressed (e.g.: depression). Able to demonstrate new learning. Follows commands and is cooperative with therapy. • Able to tolerate being out of bed everyday up to 3-4 hours. Minimum to moderate assist with transfers and ADL's. Demonstrating functional improvements with ADL's.	• Wandering • Patients with acute psychiatric disorders are not accepted • Patients with acute neurological conditions or spinal cord injuries are not accepted • No NG tubes • No ventilators or Bipap machine CPAP must be managed by the patient • Patients at risk to self/others • Cognitive impairment from a brain injury not an exclusion criteria unless MMSE score <26 • Patients requiring isolation for infectious diseases	(shared with Medical Activation) RN: 6.0 days, 4.0 evenings, 2.0 nights PSW: 7.0 days, 4.0 evenings, 2.0 nights PT: 2.2 OT: 2.2 PT/OT Assist: 2.0 SW: 1.0 Recreation Therapist: 0.5 Recreation Therapy Assist/student: 0.5 SLP: 0.5 Dietician: 0.5 Physician: 1.0
Halton Healthcare Services	General Inpatient Rehab Program	39 beds (approx. 3 used for medically complex / geriatric patients)	Populations served: • 50-60% Ortho • 10-15% Neuro incl. stroke/CVA • 9% Debility (renal pts) • 8% Medically Complex: Mostly geriatric patients with multiple co-morbidities incl. failure to thrive. Geriatrician consults 1x/week • NWB reviewed for appropriateness • Must be able to participate and learn new skills	• Ventilated patients • Psycho-geriatric patients, acute psychiatric patients • Aggressive pts who pose a risk to self and others	Charge RN: 1.0 RN 4(day); 3 (evening); 2 (night) FIM Coordinator: 0.3. RN RPN: 4(day); 2.5 (evening), 2 (night) Professional Practice Clinician (RN): 0.5 Rehab Pt. Care Manager: 0.75 Physician: MRP for individual patients plus hospitalist rotation for unaffiliated patients Physiatrist: 0.5 PT: 3.0

Mixed Rehab Units that address "Medically Complex" rehab needs (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
			• Active participation in therapy for min. 1 hour and able to tolerate 2- 3 hours out of bed per day		OT: 3.0 OTA/PTA: 3.0 SW/Discharge Planner: 1.0 Dietician: 0.4 Pharmacist: 0.4

Mixed Rehab Units that address "Medically Complex" rehab needs (Internal Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
Southlake Regional Health Centre	Complex Medical Rehab Inpatient Program	14 designated rehab beds and 20 beds in CCC	Neurological and de-conditioned patients, resulting from surgery or complex medical diagnoses • Patient must have capacity to follow instructions and participate in therapy	• Wandering • Dialysis • Aggression • Infectious illnesses	RN: (12 hour shifts) 2 (day); 2 (night) RPN (mix of 8 and 12 hour shifts): 5 (day); 4 (evening); 1 (night) Physician: 9 Physiatrist: 1 SW: 1.0 Therapeutic Rec: 0.6 Pharmacist: 0.1 PT: 2.5 (also covers acute neuro) OT: 2.3 (also covers acute floors) OTA: 1.5 PTA: 2.0 SLP: 3.26 (also covers acute floors) CDA: 0.6
Trillium Health Centre	General Inpatient Rehab Program	74 beds divided according to length of stay (short, medium, long)	Although a range of patients are treated on all units, the areas of clinical expertise include: Orthopedics, Neurosciences, Cardiac Surgery, and Complex rehabilitation. Geriatric and Medically complex patients are also included. Admission Criteria: • Patient has been screened using the Rehab Readiness Assessment Tool	• Unable to participate in a rehab program; • Functional deficits cannot be addressed by the team; • No discharge plan initiated; • Goals are not identified; • Medically unstable; • No clear diagnosis; • Infection control issues; • Patients who are a threat to	<u>Staffing</u>: This staffing level supports all populations on the 3 rehab units, not exclusive to the geriatric/ medically complex population. RN: 9 (day), 7 (evening), 5 (night) RPN: 5 (day), 4 (evening), 3 (night) Physician: • MRP model varies in each area; • Hospitalist model supports this population 7 days per week

Mixed Rehab Units that address "Medically Complex" rehab needs (Internal Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
			• Defined goals for rehab which family and patient have been involved in identifying and agree upon • Able to tolerate a rehab program offered by a multidisciplinary team • Functional deficits require a team approach. PT and OT assessments completed • Discharge plan initiated and documented • Medically stable with diagnosis and co-morbidities Rehab Finder includes detailed information about Trillium Health Centre programs	others; • Vented or highly acute patients	Physiatrist: 0.8 (also supports Stroke Unit) PT: 6.5 PTA: 1.8 OT: 5.86 OTA: 2.46 PTA/OTA combined trained: 2.5 SLP: 0.88 SW: 2.4 Therapeutic Recreation: 1.0 Dietician: 0.5 Pharmacist: 1.0 Psychology/Neuropsychology n/a Other CDA: 0.5 (In long term rehab TR, Dietician and S-LP are shared with Complex Care)

SECTION III: GERIATRIC LOW TOLERANCE LONG DURATION REHAB (LTLD)
AND
MEDICALLY COMPLEX LOW TOLERANCE LONG DURATION Rehab (LTLD) REHAB

Geriatric LTLD Rehab and Medically Complex LTLD Rehab: also known as Activation, Functional Enhancement, Complex Medical

- These programs provide a low to moderately intensive rehab program 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 units.
- For programs that identify themselves as providing Geriatric LTLD rehab, specialization is encouraged to support the development and maintenance of clinical expertise in geriatrics and multi-system issues at least in the medical staff.
- Complex Medical LTLD rehab programs are recommended for patients with multi-system issues who do not require specialized geriatric interventions. Patients accepted into these programs are adults of any age.
- Both Geriatric LTLD Rehab and Complex Medical LTLD Rehab are typically located in complex continuing care beds.

Geriatric Low Tolerance Long Duration Rehab (LTLD) Rehab (External Referrals)

Organi-zation	Name of Program	No. of Beds	Admission Criteria	Exclusion Criteria	Staffing (FTE)
Bridgepoint Health	Geriatric / Ortho Activation Unit	20 beds – geriatric 32 beds – ortho (CCC)	The Geriatric/Ortho Activation Unit provides a full range of rehabilitation services to geriatric patients who may have a combination of medical conditions and/or orthopaedic conditions and other patients whose primary diagnosis is orthopaedic in nature who require a slower-paced rehab program for a longer duration. Admission criteria include: • Patients must be medically stable and cognitively able to participate in a slower-paced rehab program (minimum of 2 days of therapy per week) • Requires nursing care to meet activities of daily living on a 24-hour-a-day basis • Geriatric patients are typically 70 years of	• NG Tube • Restraints • TPN	Across 52 bed unit: • RN: 4 (day); 3 (evening); 2 (night) • PSW 5 (day); 3.5(evening); 1.0 (night) • Physician: 1 GP with rehab specialization; Physiatrist on call • OT: 1.5 • PT:1.5 • OTA/PTA: 1.0 • SW: 0.8 • Dietician: 0.3 • Pharmacy: 0.3 • SLP: 0.3 • Communication Disorders Assist: 0.5 • Rec. Therapist: 0.5

Geriatric Low Tolerance Long Duration Rehab (LTLD) Rehab (External Referrals)

Organi-zation	Name of Program	No. of Beds	Admission Criteria	Exclusion Criteria	Staffing (FTE)
			age or older • Non-weight bearing patients are accepted • Average length of stay for orthopaedic patients is approximately 4-5 months • Average length of stay for geriatric patients is approximately 6 months		• Rec. Therapy Assist/student: 0.5
Lakeridge Health	Geriatric Assessment & Rehab Unit	32 bed unit (CCC): 25-27 beds: Geriatric rehab 4-6 beds: LTLD (primarily stroke patients) 1-2 beds: GATU	Specialized geriatric service for frail older persons (75+) with functional impairment secondary to: • general medical de-conditioning secondary to multiple pathologies, both medical and surgical; • musculoskeletal probloems such as joint surgery, replacement or fracture; • neurological disorders such as CVA, Parkinson's, MS. • vascular conditions such as CHR, CAD • generalized failure to thrive (secondary to geriatric giants such as incontinence, cognitvie impairment, depression, falls, malnutrition). • Must demonstrate capacity for learning and retention • Rehab Tolerance: approx.20 min. at least 3x per week	• Wandering • Cognitive impairment that impedes learning and retention • Safety risk to self/others • Infectious illnesses/diseases that require isolation • Primary psychiatric and psychogeriatric disorders • Activity limited to bed rest	<u>Staffing shared across 32 bed unit:</u> Physiatrist: 0.50 (with training in geriatric rehab) RN: 2 + charge RN (day); 2 (evening); 1 (night) (Nurse /Patient ratio: 1:4 (day); 1:5 (evening); 1:10 (night)) Acute Care Nurse Practitioner: 1.0 RPN: 6 (day); 4 (evening); 2 (night) PT: 2.0 OT: 2.0 OTA/PTA: 2.0 SW: 1 SLP: 0.25 Dietician: 0.5 Pharmacist: Consult basis Chaplain: Consult basis Neuropsychologist: Consult basis
Providence Healthcare	Inpatient Specialized Geriatrics Program	22 GATU beds (CCC)	• Patients who require a longer length of stay and slower-paced rehab are admitted to the geriatric assessment and treatment beds. • For patients with complex medical and psychosocial problems or recent unexplained breakdown in health or function	• Non-weight-bearing status. (May be admitted to CCC while NWB) • Aggressive behaviour • Wandering • Unable to accommodate patients with impairment	<u>Staffing is shared across 45 bed unit: Geriatric Rehab and GATU:</u> • RN: 3 (day); 3 (evening), 2 (night) • RPN: 6 (day); 4 (evening); 2 (night) • Medical director of GRU/GATU has experience and interest in geriatrics. Geriatric and psychogeriatric consultation

Geriatric Low Tolerance Long Duration Rehab (LTLD) Rehab (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
			• Patients who have a medical or surgical diagnosis from which they are recovering. Patients are frail elderly with several comorbid conditions who will benefit from further assessment and an inpatient rehabilitation program prior to returning to community living. • Specialize in older adults Understand and retain instructions • Rehab Tolerance 30-40 minutes • Discharge plan in place	from a brain injury, an acute psychiatric condition • Active TB	available • PT: 2.5 • OT: 2.5 • PTA/OTA: 2 • Rec. Therapists: 0.55 • Rec. Assistant: 0.7 • SW: 0.8 • SLP: on consult • Ward Aid: 0.5 • Clinical leader: 1 • Dietician:0.3 • Pharmacy: 0.6
West Park Healthcare Centre	Geriatric Functional Enhancement Service	26 beds (CCC)	• Primarily for older pop. (65+) with neuro, orthopaedic or medical conditions • Patients must be medically stable and all diagnostic tests must be completed in acute care before admission • Will accept non-weight-bearing patients • Patients must be cognitively intact or have sufficient cognitive capacity to participate in rehabilitation to learn and retain the information • Patients must be able and willing to participate in therapy • Must be able to participate in therapy for a minimum of 20 minutes per day • Anticipated length of stay 90 – 120 days	• Wandering • Aggressive patients • End-stage renal disease (ESRD) on peritoneal dialysis. • Psychiatric conditions that would interfere with rehabilitation. • Cognitively impaired patients who are not able to learn and carry over the information would not be considered • Active tuberculosis (TB). Infectious respiratory illnesses. • Patients younger than 65	RN: 2 (day); 2(evening); 1 (night) RPN: 3 (day); 3 (evening); 1 (night) Physician: Currently recruiting for Attending GP. At present, coverage provided by Medical Chief of Staff. Geriatrician available on monthly consultation basis. Consult from physiatry available. PT: 1.4 OT: 1 SLP: on consult Rehab Assistants 1 Recreation Therapist: on consult Respiratory Therapy: on consult

Medically Complex Low Tolerance Long Duration (LTLD) Rehab (External Referrals)

Organi-zation	Name of Program	No. of Beds	Admission Criteria	Exclusion Criteria	Staffing (FTE)
Bridgepoint Health	Medical Activation Unit	36 beds (CCC)	Patients admitted to this service have varying diagnoses and require varying degrees of activation/rehabilitation. These patients have typically had a prolonged and complicated ICU stay following a major medical illness or surgery. Patients are more deconditioned and require a longer period of moderately intensive rehabilitation. • Average age approximately 40-50 years of age although some patients may be older. • Average length of stay is 3-6 months • Patient must be cognitively, physically, medically and psychologically able to participate in a rehab program • Patient must have the potential for improvement in functional abilities with rehabilitation and has attainable, realistic goals • If receiving dialysis, patients must pre-arrange their transportation to and from dialysis visits • Average length of stay is approximately 55 days	• NG Tube • TPN • Restraints • Not dependent on active medical treatment from an acute care hospital	(shared with Medical Rehab Program) RN: 6.0 days, 4.0 evenings, 2.0 nights PSW: 7.0 days, 4.0 evenings, 2.0 nights PT: 2.2 OT: 2.2 PT/OT Assist: 2.0 SW: 1.0 Recreation Therapist: 0.5 Recreation Therapy Assist/student: 0.5 SLP: 0.5 Dietician: 0.5 Physician: 1.0
Lakeridge Health	Low Tolerance Long Duration	4-6 beds (part of 32 bed Geriatric Assessment & Rehab Unit) (CCC)	For persons with complex medical conditions and co-morbid conditions that prevent their participation in a regular stream rehabilitation program. The program serves the needs of patients suffering from recent functional impairment secondary to: • Primarily neurological disorders such as severe CVA, Parkinson's, MS • General medical de-conditioning post-	• Wandering • Cognitive impairment that impedes learning and retention • Safety risk to self/others • Infectious illnesses/diseases that require isolation • Primary psychiatric and	Staffing shared across 32 bed unit: Physiatrist: 0.50 (with training in geriatric rehab) RN: 2 + charge RN (day); 2 (evening); 1 (night) (Nurse /Patient ratio: 1:4 (day); 1:5 (evening); 1:10 (night)) Acute Care Nurse Practitioner: 1.0 RPN: 6 (day); 4 (evening); 2 (night) PT: 2.0 OT: 2.0

Medically Complex Low Tolerance Long Duration (LTLD) Rehab (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
			acute episode coupled with significant pre-morbid chronic illness and reduced functioning. • The client or their accompanying caregiver must be able to provide a subjective history of their condition, articulate their goals/objectives and provide feedback to the treating therapist. Clients must be able to follow instructions and should be able to remain an active participant in the assessment and treatment process. Must demonstrate capacity for learning (able to follow simple 2 step instructions), retention and carry-over of information presented in the therapeutic program • Rehab Tolerance: approx. 20 min. once per day; sitting balance of 20 min.	psychogeriatric disorders • Moderate to severe ABI with significant disruptive behaviours Severe dementia preventing participation in therapy	OTA/PTA: 2.0 SW: 1 SLP: 0.25 Dietician: 0.5 Pharmacist: Consult basis Chaplain: Consult basis Neuropsychologist: Consult basis
Rouge Valley Health System	Functional Enhancement Program	10 beds (Ajax-Pickering site) (CCC)	• Low intensity reactivation program for patients who have experienced a recent loss of function due to illness or injury (i.e. recent severe acute multi-system illness, stroke, chronic deteriorating illness with acute exacerbation) • Goals of program are to optimize client functioning and independence and identify potential for higher intensity rehabilitation and/or return to the community • Patients do not meet criteria for convalescent care beds in LTC (e.g.	• Need for daily intensive rehabilitation services • Significant cognitive impairment preventing assessment/interventions	Ajax Pickering Site: (10 beds) Staffing shared across 18 bed unit (8 rehab beds, 10 Functional Enhancement beds in CCC). Rehab pts. Receive rehab on daily basis; pts on Functional Enhancement beds receive rehab 2x/week) RN: 2 (day); 1 (evening); 1 (night) RPN: 1 (day); 2 (evening); 1 (night) Physician: 1 GP PT: 1.0; OTA/PTA: 1.5 OT: 1.0 SW: 0.5 SLP, Dietician, Pharmacist on consultation basis.

Medically Complex Low Tolerance Long Duration (LTLD) Rehab (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
			require > 45 days LOS) • Patients must demonstrate suitable cognition, willingness and ability to participate in therapy > 15 minutes • Demonstrate potential to attain functional goals that will positively influence level of independence and quality of life • LOS: 1 ½ - 4 months		
Toronto East General Hospital	Medium Intensity Rehab Program	15 beds (CCC)	For adult patients with general medical/surgical/orthopedic/neurological conditions. • Length of stay is 6 weeks to 3 months • May be non-weight bearing for a limited period of time not greater than 6 weeks. • Patients able to engage in socially appropriate behaviour and do not require constant supervision • Demonstrate motivation and ability to participate in program for 30 - 60 minutes • Must have potential for functional improvement and identified rehab goals prior to admission	• Severe dementia, inability to follow instructions • Wandering • Acute psychiatric episodes • Aggressive behaviour, rummaging behaviour, sexually inappropriate behaviour • Active TB • Clients undergoing chemotherapy or radiation therapy, corking trial, Dialysis (periotoneal & hemodialysis) Spinal cord injury, acquired brain injury.	<u>Staffing for RN (as of end of Sept) shared with 11 CCC patients. Allied health staffing is shared with 34 CCC pts</u> RN: 2 (day); 1(evening); 1 (night) RPN: 1 (day); 2 (evening); 1 (night) Physician 1 (for rehab pts.) PT 1.0 PTA/OTA: 1.0 OT: 1.0 OTA: 1.0 SLP: 1.0 SW: 1.0 Therapeutic Recreation: 1.0 Dietician: 0.5 Pharmacist: 1.0 Rehab Coordinator: 1 shared with 15 bed high intensity unit
Toronto Rehab	Inpatient CCC: Physical and Cognitive	32 beds – neuro-physical 16 beds – neuro-cognitive (CCC)	• For patients 18 years and older • Neuro-physical: For pts with ABI, SCI, Stroke, fractured hip, MS • Neuro-cog: For pts with some type of dementia, ABI, degenerative disorder • Must demonstrate potential to improve • Patients should be able to tolerate 30 minutes of therapy on a daily basis	• Wandering • Ventilator support • Acute psychiatric episode • Aggressive behaviour to self/others	<u>Staffing for 50 bed unit:</u> RN: 4 (day); 2 (evening); 2 (night) RPN: 7 (day); 6 (evening); 3 (night) Health Care Aides: 2 (day) Physician PT: 1.0 PTA: shared across services OT: 1:0

Medically Complex Low Tolerance Long Duration (LTLD) Rehab (External Referrals)					
Organi-zation	**Name of Program**	**No. of Beds**	**Admission Criteria**	**Exclusion Criteria**	**Staffing (FTE)**
			Monday to Friday. For those patients in the physical enhancement stream, they should willingly and actively participate in therapy		OTA: shared across services SLP: shared across services SW: 1.0 shared across 2 units Wellness Partners (in place of Therapeutic Recreationists): 3 available for 220 beds Dietician: shared Pharmacist: shared

Appendix G: Range of Staffing

To date there is no information in the literature identifying optimal staffing ratios. Consequently, we have estimated the range of staffing for a "35 bed unit" based on the present practice of three Geriatric Rehab programs* in the GTA. There are differences among the three programs. For example, in one of the programs 40% of the beds are for patients who require dialysis, in another 50% are geriatric assessment and treatment beds and 50% are geriatric rehab beds and in the third program 25% are geriatric assessment and treatment beds and 50% provide diagnosis specific rehab beds and 25% provide general geriatric rehab beds.

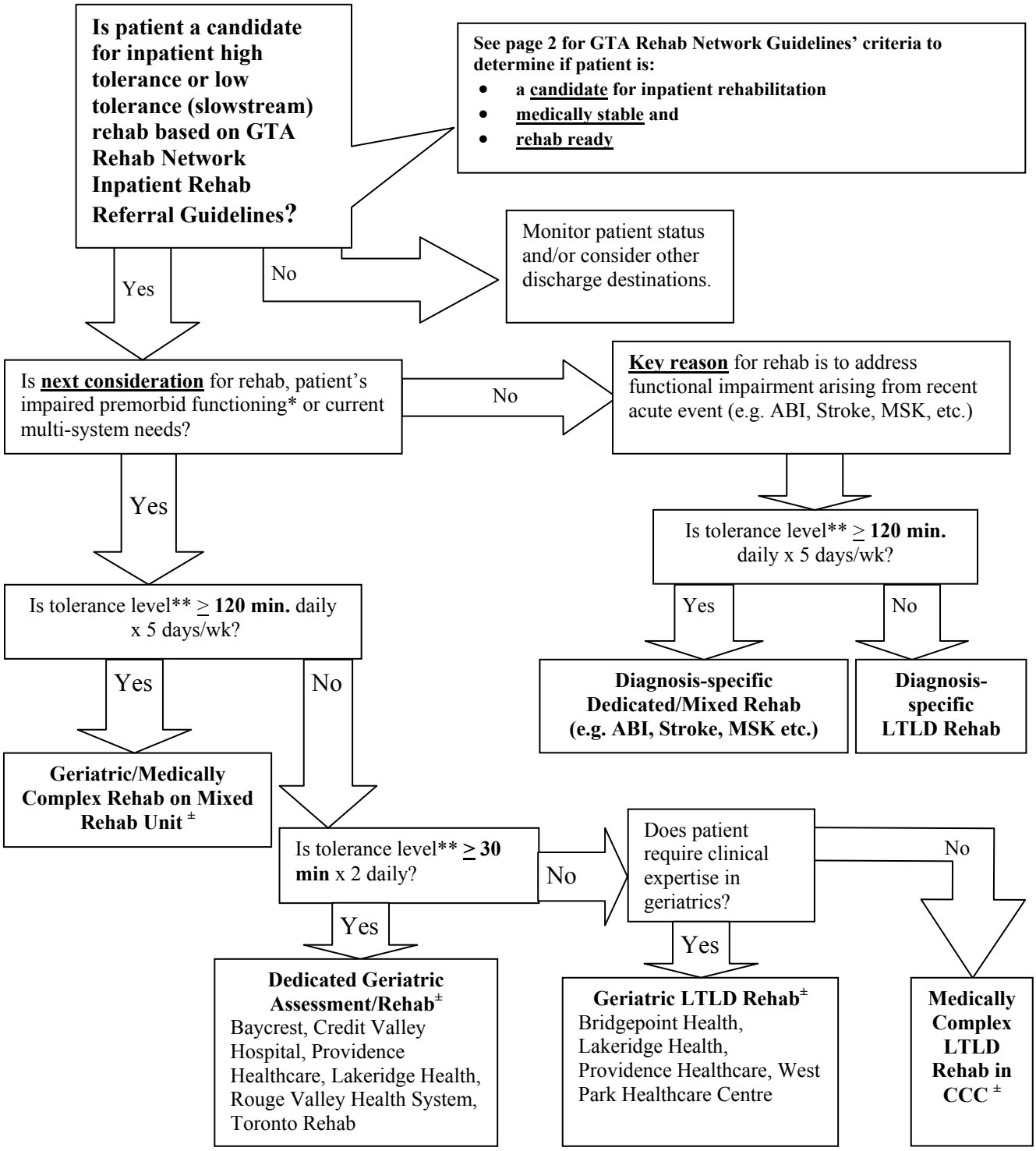
Staffing Ranges

Staffing	Staff Range/35 Beds
Physician	0.70-1.40
RN(days)	2.45-6.30
RPN(days)	3.50-6.30
Total Nursing (days) (RNs+RPNs)	6.65-12.60
RN (evenings)	2.28-3.67
RPN Evenings	2.28-3.67
Total Nursing (evenings) (RNs+RPNs)	4.55 -7.35
RN (nights)	1.50-2.45
RPN (nights)	1.05-2.45
Total Nursing (nights) (RNs+RPNs)	2.10-4.90
Physical and/or Occupational Therapy	5.25-8.75
Recreational Therapy	0.7-1.05
Social Work	0.7-2.45
Speech Language Path	on consult-0.70
Dietician	0.25-1.05
Pharmacist	0.38-0.70

*Geriatric Rehab Programs:

Baycrest:	32 beds (8 geriatric rehab, 8 geriatric MSK, 8 geriatric Neuro/Stroke, 8 GATU)
Providence:	45 beds (22 GATU, 23 geriatric rehab)
Toronto Rehab:	28 beds (12 haemodialysis geriatric rehab, 16 geriatric rehab) (Toronto Rehab's Geriatric Psychiatry 20-bed unit is not included in this analysis)

Appendix H: Inpatient Rehab Triage Guidelines for Geriatric Patients



* See Pre-Morbid Function Screen on page 3.

** Tolerance denotes participation in all activities scheduled with therapy and nursing staff.

± For definitions regarding these types of programs, please see page 4. A listing of current programs for each category can be found in the GTA Rehab Network's Inventory of Inpatient Rehab Programs for Geriatric/Medically Complex Patients

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 <u>candidate</u> 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 <u>Medical Stability</u> …

- ✓ 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 <u>Rehab Readiness</u> …

- ✓ 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.

Pre-Morbid Function Screen*

1. **Nutrition**
   Has patient had unanticipated weight loss in the last year (i.e. clothes fit loosely or weight loss ≥ 5% of body weight)? **Yes** ☐ **No**☐

2. **General Health Status**
   Has patient had two or more admissions to hospital in the last year? **Yes** ☐ **No**☐

3. **Medication use**
   Did patient use 5 or more prescription medications on a regular basis? **Yes** ☐ **No** ☐

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)? **Yes** ☐ **No** ☐

5. **Continence**
   Did patient have a problem with losing control of his/her urine? **Yes** ☐ **No** ☐

6. **Mobility**
   Has patient had a fall in past year? **Yes** ☐ **No** ☐

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:

Bergman H, Beland F, Karunananthan S et al. Development of a framework for understanding and studying frailty. Gerontologie et Societe 2004:109:15-29.

Fried LP, Tangen CM, Walson J, et al. Frailty in older adults: evidence for a phenotype. J. Gerontology A Biol Sci Med Sci2002:57A(3):M146-M156.

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Rockwood K, Hogan DB, MacKnight C. Conceptualization and measurement of frailty in elderly people. Drugs Aging 2000; 17:295-302.

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

Glossary of Definitions for Geriatric Rehabilitation[36]

Geriatric Rehabilitation:
A program designed to optimize 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. Geriatric rehabilitation provides evaluative, diagnostic and therapeutic interventions to restore functional ability or enhance residual functional capacity in elderly people with disabling impairments.[37]

Dedicated Geriatric Assessment/Rehab
(also known as Geriatric Rehab Units (GRU), Geriatric Assessment and Treatment Units (GATU) and Geriatric Assessment and Rehab Units (GARU))
- These programs provide a moderately intensive rehab program provided by an interdisciplinary rehab team with expertise in geriatric assessment and treatment.
- Rehabilitation includes assessment and treatment of geriatric syndromes-instability or falls, isolation or depression, cognitive impairment including delirium and dementia, incontinence, immobility, poly-pharmacy and inadequate nutrition. The key differentiating feature of geriatric rehab is that the assessment and treatment of these multi-dimensional factors are as much of the rehab focus as is the illness or injury which directly led to the most recent hospitalization. In geriatric rehab units the emphasis is on restoration of functional status.
- Geriatric rehab treats patients who are typically frail, have multiple co-morbidities and functional impairment with complex underlying medical and functional problems, unexplained pre-morbid problems coping at home and/or an insult or complicated course in hospital such as delirium, pneumonia or a fracture.
- Typical length of stay based on the Toronto Regional Geriatric Program guidelines for GATUs/GARUs is 4-6 weeks and 4-12 weeks for GRU.
- This type of rehab may be located in designated rehab beds or complex continuing care beds.

Geriatric/Medically Complex Rehab on Mixed Units:
(also known as General or Medical Rehab)
- These programs provide an intensive rehab program by an interdisciplinary rehab team.
- Although rehab providers assess/treat a variety of diagnostic/rehab population groups, specialization is encouraged where there is a sufficient critical mass to support the development and maintenance of clinical expertise in geriatrics and multi-system issues at least in the medical staff.
- Geriatric patients who are appropriate for a mixed unit are patients whose primary diagnosis falls outside of the other rehab population groupings (e.g. MSK, Stroke) and whose premorbid functioning was mild to moderately compromised.
- Typical length of stay is 2-8 weeks; some rehab units located in acute care hospitals have a 3-14 day length of stay.
- This type of rehab is typically located in designated rehab beds in community hospitals.

Geriatric LTLD Rehab and Medically Complex LTLD Rehab:
(also known as Activation, Functional Enhancement, Complex Medical)
- These programs provide a low to moderately intensive rehab program 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 units.

[36] These definitions have been developed as part of the GTA Rehab Network's Definitions initiative.
[37] 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.

- For programs that identify themselves as providing **Geriatric LTLD** rehab, specialization is encouraged to support the development and maintenance of clinical expertise in geriatrics and multi-system issues at least in the medical staff.
- **Medically Complex LTLD** rehab programs are recommended for patients with multi-system issues who do not require specialized geriatric interventions. Patients accepted into these programs are adults of any age.
- Both Geriatric LTLD Rehab and Medically Complex LTLD Rehab are typically located in complex continuing care beds.

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