Regional Geriatric Program of Eastern Ontario Regional Geriatric Rounds

Are you confused by the Geriatric in-patient rehabilitation referral and selection process?

A review of the spectrum of Geriatric in-patient rehabilitation services available to older Ottawa Hospital in-patients

Dr. Scott Wiebe
The Ottawa Hospital - Short Term Rehabilitation

Dr. Frank Molnar
The Ottawa Hospital - Geriatric Assessment Unit

Dr. Anne Harley
Bruyère Continuing Care – Geriatric Rehabilitation
Bruyère Continuing Care – Restorative Care

Dr. Sue Dojeiji
Specialized (PM&R) Rehabilitation Services
TOH Short Term Rehabilitation Unit (STR)

- **Dr. Scott Wiebe**
  - Specialist in Physical Medicine and Rehabilitation whose clinical practice includes attending on STR, outpatient clinics in General Rehabilitation and Electromyography / Nerve Conduction Studies.
STR Description

- The STRU is an in-patient unit at The Ottawa Hospital specializing in the interdisciplinary assessment, treatment, and rehabilitation of adults with functional deficits who have a high likelihood of returning home once their functional status has been optimized sufficiently for a safe return home.

- Focus on comprehensive assessment and offers patient-centered care in partnership with the patient, family and treating team.
STRU is a high-turnover service:
- 28 beds
- Average LOS 12 days
  - 21 days a few years ago – early D/C, 7 day Tx
- 750 patients in 2009
- >98% occupancy
  - Operating over cap
  - Rare waiting list – worst case scenario 4 days

Staffing:
- STRU is staffed for rehab service, not acute medical/surgical care:
  - MDs: 5 rotating GPs
  - 2 physiatrists
  - 0 residents
STR Description

- Staffing:

  Patient: RN/RPN ratios:
  6:1 on days and 9-10:1 on nights (cf. 4-5:1)
  Nursing as a vital part of the rehab team
  Similar to GAU, APU
  Difficult to care for medical patients

Consult RNs

  Specialized rehab training
  1000-1200 consults per year
  ~75% accepted
  Review often with MDs
STR Description

- **Staffing:**
  
  Patient: PT ratio:
  
  7:1 weekdays
  
  2 PTs on weekends
  
  Patient: OT ratio:
  
  7:1 weekdays
  
  1 OT on weekends
  
  **Speech Language Pathology**
  
  SLP 0.3 FTE
  
  **Social Work**
  
  SWs 1.6 FTE
Referral criteria

- Require assessment and management of **functional deficits** that have potential for improvement or reversibility and anticipated discharge of 2-3 weeks.
Referral criteria

- Require **assessment and treatment by a specialized interdisciplinary team** (including Physiatrists/Family MDs, Rehab nursing, OT, PT, SW, and/or SLP) prior to discharge due to changes in their functional status from baseline.
Referral criteria

- Basic issues that require an interdisciplinary rehab assessment by STR include:
  - Impaired mobility (post-op or otherwise)
  - Deficits in ADL/IADL performance temporarily precluding safe return home
  - Orthopedic surgery ~70%
  - “Deconditioning”
  - Mild stroke; other neurological disease
Inclusion Criteria

- Medically stable
- Retains instructions
- Pain controlled **
- >2 hrs/day sitting tolerance
- >1 hr/day therapy tolerance
- Willing to participate
- Important deficits
- Social situation relatively stable

- Complexity
Exclusion Criteria

- Too ill or cognitively impaired
- Need for continuous or intensive monitoring
- Lack of established diagnosis
- Incomplete medical investigations
- Planned treatments not initiated
- Active chemo/radiation
- Requires a sitter
- Other behaviours precluding rehab participation
- LTC (case-by-base discussions) *
- >1 assist (ie 2-person assist or mechanical lift)
- Labour-intensive treatments/nursing care ie TPN, VAC, PD

*** Accepted to another rehabilitation service ***NOT Typically Excluded

- Weight-bearing status (NWB, PWB, TTWB)
- Palliative for end-stage disease (case-by-case)
TOH Geriatric Assessment Unit (GAU)

- **Dr. Frank Molnar**
  - Member of the Division of Geriatric Medicine, rotating through consult service at General and Civic campuses as well as attending on GAU
  - Medical Director, TOH Geriatric Day Hospital

- **Thanks to Marion Agnew**
- **Thanks to Dianne Rossy & Helen Zipes**
  - Algorithms and program descriptions
Comparison with STR

STR
- 28 beds
- LOS 12 days
- > 98% occupancy
- 1000-1200 consults
  - 750 patients admitted
  - ~75% accepted

GAU (2009)
- 24 beds
- LOS 15-20 days
- close to 100% occupancy
- 1258 consults seen by TOH geriatricians
  - 144 referred to GRU from civic campus
    - 11.4%
  - 444 admitted to A1 (GAU)
    - 35.3% (no beds to accept more)
  - 47% accepted overall
History – understanding GAU’s challenges and limitations

- The GAU is an understaffed service because the staff resources were never appropriately increased to adapt to major changes in the patient population cared for:
  - The GAU patient profile has changed significantly over the years. Since Short-Term Rehabilitation (STR) has been developed and the Bruyere Geriatric Rehabilitation Unit (GRU) has switched from longer-term rehab to shorter-term rehab (both good developments for TOH), many of the patients traditionally cared for on GAU in the 1990’s are now cared for on STR and GRU. The GAU has shifted to caring for more complex and ‘heavy’ patients.
GAU is under-resourced

**STR**
- RN:patient 6:1 days, 9-10:1 nights
  - Same RN load as APU
  - > 4-5:1 referral services
- PT:patient
  - 7:1 weekdays
  - 2 PTs weekends
- OT:patient
  - 7:1 weekdays
  - 1 OT weekends
- SLP 0.3 FTE
- SW 1.6 FTEs

**GAU**
- RN:patient 6:1 days, 8:1 nights
  - (*patients are sicker + more cognitive issues than any other rehab service*)
  - Same RN load as APU
  - > 4-5:1 referral services
- PT:patient
  - 16:1 weekdays
  - 0 PTs weekends
- OT:patient (*more cognitive*)
  - 11:1 weekdays
  - 0 OTs weekends
- SLP 1.0 decreasing to 0.5 (split inpatient and outpatient)
- SW 2 FTEs
History – understanding GAU’s challenges and limitations

- Due to the change in the patient profile to more complex and ‘heavy’ patients without simultaneous increase in staffing, the GAU is an understaffed / under-resourced service:
  - One of the highest **Patient: Nurse ratios** in TOH; 6:1 on days and **8:1** on nights (similar to Awaiting Placement Units). Acute wards have a 4:1 ratio on days. This limits ability of GAU to accept complex patients
  - One of the highest **Patient: Physiotherapist ratios** in the hospital; **24 patients for 1.5 Physiotherapists**. **No weekend Physiotherapy.** This limits ability to provide rehab.

- Administration are aware of this problem and are actively trying to address it. Some corrections may need to wait until we are out of a deficit position.
How can GAU do the best it can with the limited resources available (understanding how / why only 35% of referrals are selected for GAU)?

Understanding the 2 Tiered selection (i.e. targeting) process

Referral Criteria ≠ Selection Criteria
Given that there are usually not enough beds to accept all patients meeting Referral Criteria, a 2 Tiered process is applied (Referral Criteria ≠ Selection Criteria)

- **Referral Criteria**
  - Stable theoretical (often written – see handout) criteria of who might benefit from a service if there were unlimited resources. Limited as it is impossible to capture all the nuances of every complex case in a single document.
  - Referral Criteria also include patients who could benefit from outpatient post-discharge follow-up

- **Selection (Targeting) Criteria**
  - Dynamic / variable criteria and judgements employed by experienced clinicians to select a subset of patients meeting the Referral Criteria who meet the referral criteria and can be cared for given current resource limitations (waiting list, ability of GAU staff to care for patients already on GAU).
  - ‘Value added principle’: Patients most likely to benefit from GAU (as opposed to remaining on referring ward) are prioritized.
  - Selection Criteria limited to inpatient transfer. Some who are not selected for GAU may be appropriate for outpatient post-discharge follow-up
Referral criteria

- Require assessment and management of *complex medical, functional and psychosocial geriatric problems* who have potential for improvement or reversibility and anticipated discharge of 2-3 weeks but do not need continuous or intensive monitoring.
Referral criteria

- Require **short term assessment & reactivation** before discharge from hospital (2-3 weeks), e.g. post hip fracture; usually with other complicating medical/functional/psychosocial problems.

- “Typical” patient usually has advanced age, cognitive decline, & / or repeated hospital admissions.
Referral criteria

- Require *assessment by a specialized interdisciplinary team*, (i.e., Geriatrician, Nursing, OT, PT, SW, SLP, R.D., and Pharmacist) prior to discharge due to change in their social/care needs, specific safety concerns.
Referral criteria

Common **geriatric problems** that may require a GAU medical evaluation and an interdisciplinary assessment may include:

- Falls / impaired mobility
- Medication issues (polypharmacy, non-compliance or non-adherence)
- Changes in cognition: dementia / delirium / depression
- Problems with Activities of Daily Living / Instrumental Activities of Daily Living
- Unexplained physical decline / weight loss / failure to thrive.

Concurrent medical conditions:

- CHF / diabetes / hypertension / osteoporosis / Parkinson’s disease / postural hypotension/ **one of few sites where hemodialysis patients can receive rehab**
Exclusion Criteria

- so ill or delirious that he / she cannot partake in the assessment or rehabilitation program
- need continuous or intensive monitoring (e.g. vital / neuro signs ≥ Q4H, glucoscans ≥ Q2H, patients with ↑ temperature)
- require a sitter
- have a previously evaluated end-stage dementia
- going to long-term care or admitted from LTC (case discussions may occur)
- not demonstrating mobility/ ambulation potential- has shown little recovery to previous level
- require a mechanical lift
- 2 person assist with little evidence of recovery to 1 assist
- requires slow stream rehabilitation
- needs palliative care for end stage disease
- unwilling to participate in assessment and program activities
Exclusion Criteria

- Require nursing care needs beyond available staffing levels than A1 nursing resources can accommodate:
  - epidural, intrathecal or intravenous PCA
  - VAC dressings or multiple complex dressings daily
  - tracheotomy tubes / Passey Muir valves
  - Patients with new ostomies must have at least begun to learn to empty their bag prior to transfer to A1

- Significant Behavioural problems
  - As A1 has less staffing than other wards it cannot manage significant behavioural problems
Selection (targeting) Criteria
How we select from among those who meet the Referral criteria

Too Well
• Ready for discharge (or will be ready in a few days – GAU transfer will delay discharge and increase length of stay)
• Issues can be dealt with as out-patient
• No value added to coming to GAU

Meet Referral Criteria (could benefit from GAU if resources available)
GAU does not have enough beds or resources (lowest RN and PT resources in hospital) to accept all patients who meet Referral Criteria and could benefit. It is the job of the Consult Team is to prioritize and select the subset who are most likely to benefit and that GAU can care for with limited GAU resources given fluctuating TOH demand.

Too Unwell
• Little to no potential for improvement
• For LTC
• Not ready for GAU – Refer to “GAU Exclusion Criteria”
Important Message

- If the hospital is over-capped it does not benefit TOH to transfer internally. You should be thinking about transferring back to a sending hospital if patient was transferred from an outside hospital or to rehabilitation services outside the hospital such as:
  - Bruyère Continuing Care
    - Geriatric Rehabilitation Unit (GRU)
    - Restorative Care
Bruyère Continuing Care
- Geriatric Rehabilitation Unit (GRU)
- Restorative Care

Dr. Anne Harley

- Specialist in Care of the Elderly who has worked in Complex and Continuing Care for 5 years, and Geriatric Rehabilitation for the last 11 years.
- Assistant Professor in the Department of Family Medicine, Program Director for the Care of the Elderly PGY3 training program and Chief of the Department of Care of the Elderly at Bruyère Continuing Care.
GERIATRIC REHABILITATION

Presented by:
Dr. Anne Harley, CCFP, FCFP
Chief, Care of the Elderly
Geriatric Rehabilitation
April 23, 2010
Geriatric Rehabilitation

Bruyère Continuing Care

St-Louis Residence  Elisabeth Bruyère Hospital  Saint-Vincent Hospital
Geriatric Rehabilitation

- 60 bed unit (6 QRU)

- 2 floors, each with dining room, gym, OT therapy room and kitchen
Geriatric Rehabilitation

- To provide rehabilitation to patients >65 years, who also require an interprofessional geriatric assessment

- Goals are to improve function, identify and treat geriatric giants, fine tune medical conditions and return to community living

- LOS 3-7 weeks

- Average LOS 35 days

- Discharge destination 85% home/Retirement Home
Geriatric Rehabilitation – Referral Sources

- TOH *
- QCH *
- Montfort
- GAOT
- Family Physicians
- Specialists
- Day Hospitals
- Regional or other Provincial hospitals

(* Denotes may go first to Convalescence bed)
Geriatric Rehabilitation – Inclusion Criteria

65 years and older

- Medical stability: clear diagnosis and comorbidities identified, these should not preclude participation in rehab program
- Realistic, specific and measurable functional goals
- Tolerates therapy sessions at least 1 hour twice a day
- Cognition: must have the capacity to learn, retain and demonstrate carry over of information between therapy sessions
- WBAT on affected limb
Typical Diagnoses

- Hip fracture
- Multiple fractures
- Deconditioning following a medical or surgical admission
- Neurological conditions: Parkinson’s Disease
  Spinal Stenosis

What we address:

Falls, Incontinence, Polypharmacy, Pain, Depression, Delirium, Dementia, Social Isolation, Osteoporosis, Malnutrition
Geriatric Rehabilitation: Exclusion Criteria

- Hemodialysis, peritoneal dialysis
- Chemotherapy/Radiotherapy treatments in progress
- TPN
- 1:1 Supervision required
- Use of restraints
Geriatric Rehabilitation: Team Members

- Nursing
- Physiotherapy
- Occupational Therapy
- Social Work
- Neuropsychology
- Speech Language Pathology
- Dietician
- Pharmacy
- Spiritual Care
- Care of the Elderly MDs
- Recreation Therapy
Physiotherapy

- 2 large gyms and use of Rehab assistants to increase therapy time
Occupational Therapy

- Kitchen assessments, Home visits
Pharmacy

- Self medication program and weekly medication review
Liaison with the community

- Day and weekend passes prior to discharge
- Family days, family conferences
- Recreation therapy provides links to day programs and appropriate community recreation activities post discharge
- CCAC case worker on site
Challenges

- No direct access to ALC beds
- Limited access to diagnostics during evenings/night
Geriatric Rehabilitation

Contact us

• Sharon Warkentin, Admissions Coordinator
  613 562-6262 ext. 1488
• Dr. Leslie Anne Bailliu, Medical Director
  613 562-6262 ext. 4066

www.bruyere.org

Elisabeth Bruyère Hospital
Geriatric Rehabilitation
Restorative Care

Presented by:
Dr. Anne Harley, CCFP, FCFP
Chief, Care of the Elderly
April 23, 2010
St Vincent Hospital

- Complex Continuing Care Program
- 336 beds
Programs available

Complex
Hemo/Peritoneal Dialysis
Ventillators
Complex Medical

Restorative
Low Intensity Stoke
Restorative Care
Wound

Supportive
Restorative Care

53 beds

25 Restorative

18 Low Intensity Stroke Rehabilitation

10 Wound care
Restorative Care: Goals

Deliver low intensity rehabilitation

- To improve function
- To decrease burden of care in final discharge setting
- LOS 90 days
Admission criteria to restorative care

• Late loss ADL

• Must require hands on assistance for at least 3 of the following:
  – Bed Mobility
  – Transfers
  – Eating
  – Continence
Restorative Care: Admission Criteria

- Potential for functional recovery – measurable goals identified
- Medically stable – clear diagnosis and comorbidities identified, should not preclude participation in rehabilitation
- Able to tolerate 30 minutes of therapy per day
- No age restrictions
- Capacity to learn/retain and carry over new info
Restorative Care: Typical Diagnoses

- Stroke and Stroke like syndromes
- Severe Deconditioning
- Wounds – Stage 3, 4, X pressure ulcers, Diabetic / PVD ulcers
- Post trauma
- Post ICU/Prolonged hospitalization
- Usually under 65 years
Restorative Care: Team Members

- Nursing
- Physiotherapy
- Occupational Therapy
- Social Work
- Psychology
- Speech Language Pathology
- Dietician
- Pharmacy
- Spiritual Care
- Family Physician
- Recreation Therapy
Discharge Destinations

- Home
- Long Term Care
- Retirement Home
- Another care stream at St Vincent’s
- Geriatric or Stroke Rehab at Elizabeth Bruyère Hospital
Restorative Care: Challenges

- Limited access to diagnostics/imaging
- Limited specialist support
Restorative Care

Contact us

• Wanda Assang, Clinical Admission Coordinator
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• Dr. Jean Chouinard, Medical Director,
  Chief of CCC
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Stroke and Other PM&R Specialized Rehabilitation Services

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What do you think?

1. How many inpatient stroke rehabilitation beds are there at Elisabeth Bruyere?

2. How many inpatient rehabilitation programs exist at The Ottawa Hospital Rehabilitation Centre?

3. What are the odds that the Sens will win the Stanley Cup NEXT year?
Stroke Rehabilitation Services

- High intensity stroke rehabilitation
  - 30 beds in Elisabeth Bruyère
  - Daily therapies; up > 2 hours/day
- Low intensity stroke rehabilitation
  - 18 beds in Saint Vincent
  - Therapy to patient tolerance; up > 1 hour/day
- Ability to transfer within the two programs
RITTS

- Electronic referral system
- Access to inpatient stroke rehabilitation
- Available on myTOH portal
- Live Sept 2009
  - TOH, Bruyere, QCH, Hawkesbury and Pembroke linked
- Clinical assessment coordinators review document
  - FIM, age, ADL info, tolerance
- Review with MD to determine which program
- Preliminary data shows faster admit time
- **Can still have Physiatry consultation**
High Intensity Stroke Rehabilitation

- Average age - 68 years
- Average length of stay - 52 days
- Discharge home who came from home - 87%
- Discharge to LTC – 2%
TOHRC PM&R Rehabilitation

- Regional provider for specialized physical rehabilitation services
- 62 beds
- 3 “Streams”
  - Locomotor, Neurospinal, Neurocognitive
- 380 admissions to all programs last year
- Average age – 55 years
- Average LOS – 52 days
- 86% went home who came from home
- 2% went to LTC
Locomotor Stream – Ward A

- Pulmonary
  - 66 years old, 32 days LOS

- Amputee
  - 59 years old, 39 days LOS

- Complex Orthopedic
  - 60 years old, 39 days LOS
Neurospinal stream – Ward B

- Spinal Cord Injury Rehabilitation (includes MS)
  - 53 years old, 81 days LOS

- Complex Neuro Rehabilitation
  - AIDP and other polyneuropathies
  - Myelopathy
  - Myopathies
  - 50 years old
  - 65 days LOS