AGNEWPECKHAM

HEALTH CARE
& FACILITY
PLANNERS

REACTIVATION CARE CENTRE – A CENTRAL LHIN HOSPITALS COLLABORATIVE

A STRATEGY FOR ENHANCED ACTIVATION

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Project Overview

Project Overview

Background

In August 2017, a modified Stage 1 Proposal and Stage 2 Functional Program was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by five partner hospitals in the Central Local Health Integration Network (Central LHIN). The submission addressed the need to re-open inpatient bed capacity for a five-year period at Humber River Hospital's Finch site (now called the Reactivation Care Centre – A Central LHIN Hospitals Collaborative) to accommodate

- patients waiting for an alternate level of care (ALC) from five partner hospitals, including: Humber River Hospital (HRH), Mackenzie Health (MH), Markham Stouffville Hospital (MSH), North York General Hospital (NYGH) and Southlake Regional Health Centre (SRHC)
- complex continuing care (CCC) and rehabilitation patients from MH

The rationale for opening the Reactivation Care Centre – A Central LHIN Hospitals Collaborative (RCC), for ALC and CCC/rehabilitation inpatient services is centered on ensuring patients receive the right care, in the right place, at the right time. An increasing number of patients in acute care settings are waiting for an alternate level of care in the Central LHIN, challenging acute care capacity in the region. Consequently, patients receive care in unsafe and unconventional surge spaces such as auditoriums, gymnasiums, activity rooms and hallways during periods of peak activity.

ALC patients require restorative care and reactivation to maintain or improve their functional capabilities, strength, tolerance and cognitive status. Acute care settings are not optimal environments for this level of care as

- care and staffing resources are prioritized for more acutely ill patients
- there is a significant difference between acute and sub-acute care with regards to the staffing mix and expertise
- acute care units typically do not accommodate space and facilities that support restorative care (i.e. dining and activity rooms)
- treatment and the resolution of an acute episode is the focus of acute care, whereas restorative care aims to optimize patients' function in preparation for discharge

The strategy proposed in the modified Stage 1/Stage 2 submission was two-fold:

1. Relieve system pressures by creating additional inpatient acute care capacity
2. Create an improved setting and model of care for patients requiring sub-acute services

The purpose of this document is to describe, in more detail, a model for providing enhanced activation for ALC patients at the RCC. It will provide an overview of the ALC issue within the Central LHIN and the factors driving the need for a more structured and goal oriented approach to caring for patients designated as ALC.

Factors Driving Change

An aging demographic has resulted in unique healthcare challenges across Ontario and within the Central LHIN.

Alternate Level of Care is a designation given to patients who occupy a bed in a hospital who do not require the intensity of services provided in this care setting. Patients may be waiting for an alternate level of care while occupying a bed in an acute, complex continuing care, mental health or rehabilitation bed.[1] They require an alternate level of care such as long term care (LTC), inpatient rehabilitation, palliative care or home with support.

Individuals waiting for an alternate level of care are most frequently seniors aged 75 years and over. These patients are at risk of deconditioning, nosocomial infections and iatrogenic injury, affecting their future health status with increasing stays in hospital settings.[2] ALC patients, frequently having poor functional ability following an acute episode, often deteriorate further while waiting in an acute care setting. They do not qualify for rehabilitation programs, often because they are not able to meet either the cognitive or physical demands of an intensive program. However, ALC patients do benefit from lower intensity, restorative care programs and therapies that are not typically available in the acute care setting.

ALC Patient Days in the Central LHIN

According to the Central LHIN ALC Collaborative Annual Report (2017), the Central LHIN's ALC rate of 14.5 per cent is similar to the provincial ALC rate of 14 per cent. Unfortunately, compared to other regions, the Central LHIN is the most under-bedded region in the province. As the ALC rate continues rising, the throughput ratio remains at less than 1, indicating that fewer cases are being discharged than the number of new cases designated as being ALC.[3]

Approximately 84 per cent of ALC days were attributed to patients waiting for discharge to LTC.[4] Other patients waited for transfer to a rehabilitation program (6 per cent of ALC days) or alternative discharge destinations including assisted living, complex continuing care, convalescent care, palliative care, or home (10 per cent of ALC days).[5]

[1] Central LHIN ALC Collaborative Annual Report, 2017.
[2] Ibid.
[3] Central LHIN ALC Collaborative Annual Report, 2017.
[4] Ibid.
[5] Ibid.

Impact

Health System and Central LHIN Hospitals

Increasing ALC rates place stress on the regional health care system, which is adjusting to accommodate and support an aging and growing population. In the Central LHIN, the use of acute care beds to accommodate patients waiting for an alternate level of care has contributed to insufficient acute care capacity. During the 2016 flu season, MH, NYGH and SRHC surpassed capacity and consequently provided inpatient services in spaces not appropriate for patient care. HRH and MSH were close to capacity that was planned to meet needs to approximately 2020. Hospitals across Ontario, including those in the Central LHIN, struggle with increasing demands for acute care services. This challenge can be mitigated by improving patient flow through acute care services and transitions between levels of care.

Patient Care

Similar to other elderly patients in acute care, ALC patients often experience functional decline and are at risk for adverse events while waiting for an appropriate discharge destination. The resources required to support these patients are typically not available in the acute care setting.

Within the population of patients waiting for LTC placement, approximately 19 per cent of those waiting for longer than 30 days have been identified as having behavioural issues.[6] These patients may require additional supervision, or would benefit from placement on a secure unit. Inpatient units designed for acute care are not equipped to meet these needs, posing additional risk to patients with behavioural issues or a tendency to wander.

Context for Action

In January 2017, the MOHLTC identified over 300 weekly open acute ALC cases in Central LHIN hospitals. The ALC rate has been rising steadily since 2014. With a throughput ratio below 1, the ALC population continues to grow. The RCC is a short term, interim strategy to increase ALC and subsequently, acute care capacity within the Central LHIN. The RCC will offer specialized care for ALC patients, which includes an enhanced activation program that aims to maintain or improve patients' functional capabilities and cognitive status prior to discharge.

[6] Central LHIN ALC Collaborative Annual Report, 2017.

Strategy for Enhanced Activation

Strategy for Enhanced Activation

Collaborative Planning

Work to Date

In December 2017, the Humber River Hospital Finch site will re-open under the name Reactivation Care Centre – A Central LHIN Hospitals Collaborative (RCC). The RCC will include five ALC units, which will accommodate patients from each of the five partner hospitals. While each ALC unit will be governed and operated by a different hospital, the partner hospitals have collaboratively planned over many months to develop a common approach that will ensure a consistent scope of services for all ALC patients across the five units.

A key benefit of this innovative service delivery model is the opportunity to provide specialized programming that would typically not be available to patients waiting for an alternate level of care. Programming will aim to activate patients, contributing to the restoration and/or maintenance of social, cognitive and physical functioning.

Additional planning was conducted with the Central LHIN and five partner hospitals to develop a model of care for enhanced activation.

In September 2017, a working group was convened with the purpose of designing a common approach to enhanced activation. The group included staff from each of the five partner hospitals as well as representatives from the Central LHIN. Emerging practices and existing models were presented to facilitate discussion with regards to

- program goals
- guiding principles for enhanced activation
- common characteristics and needs of specific ALC patient populations

Small groups with cross representation from the Central LHIN and partner hospitals were tasked with identifying the scope of services, specific interventions/activities and frequency of interventions for enhanced activation. The groups were given a patient persona for consideration as they developed programs that addressed the specific needs of different types of ALC populations.

The outcomes of the working session and collaborative planning to date are a service delivery model for services provided at the RCC and, more specifically, a model for providing care in a setting designed to address the unique needs of patients designated as ALC. The notes from the working session are summarized in Appendix A.

Service Delivery Model

The service delivery model at the RCC is a unique, collaborative model between five hospitals. The five partner hospitals, in collaboration with the Central LHIN, have developed a specialized model of care for ALC patients which reflects the MOHLTC's guidelines for an assess and restore approach and focuses on enhanced activation typically not provided in acute care settings.

The RCC also aims to divert long term care (LTC) placement for a proportion of ALC patients who may benefit from enhanced activation and be able to return home or to another community setting with support. Home and Community Care coordinators will be fully integrated with Centre programs to actively explore alternatives to LTC for patients who are able to restore some strength, mobility and functional skills.

Model of Care

Care Philosophy

Restorative Care

The RCC will use an assess and restore approach to care, as outlined in the Assess and Restore Guideline.[1] According to the guideline, assess and restore interventions include bundles of personalized, short-term rehabilitative and other restorative care services that are

- delivered by integrated teams that include regulated health professionals with experience in geriatrics
- designed with goals of increasing strength, mobility, and functional ability

Assess and restore interventions are most commonly targeted for frail seniors who have recently lost functional ability following an acute medical event or general decline in health. These seniors are at risk of imminent hospitalization or, if already in acute care, discharge to LTC. Seniors selected for restorative care must have restorative potential, or the potential to regain some functional ability and benefit from low impact activities meant to increase strength and function.

Patients eligible for RCC programs will benefit from Type 3 Recuperation Interventions, as described in the Assess and Restore Guideline. These patients

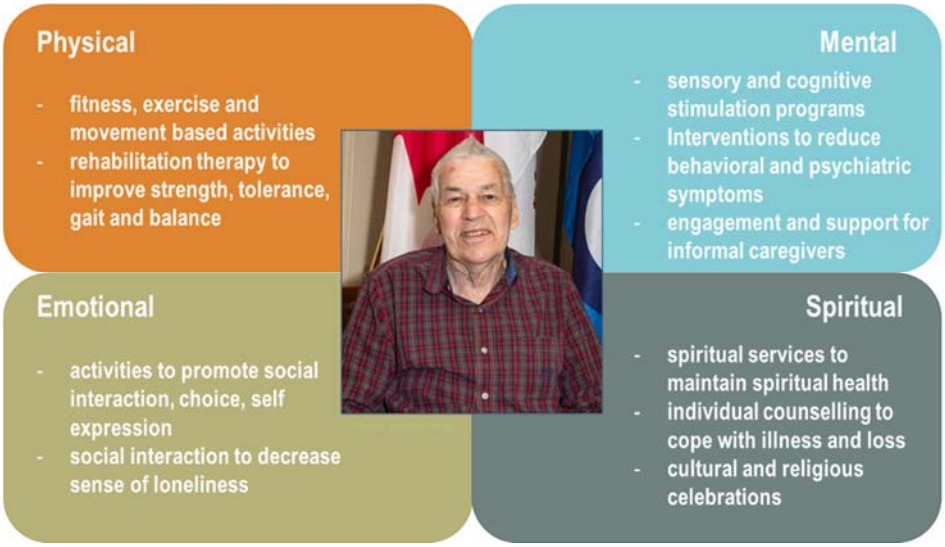
- require 24/7 nursing support, but are more stable than those requiring acute care
- are capable of time limited, low intensity restorative care although they do not have either the physical or cognitive capacity to participate in an intensive rehabilitation program
- benefit from daily activation, mobilization, and strengthening activities

A subset of patients, also designated as ALC, may not have restorative potential. These patients, who will be waiting primarily for placement into LTC, will also benefit from restorative therapy. However, the aim of therapy will be to maintain current function and prevent further decline.

Regardless of functional ability, all patients will benefit from a holistic approach to enhanced activation. A holistic approach is one that considers the whole person, and includes activities that address four aspects of health as outlined in Figure 1.

[1] Assess and Restore Guideline, Ministry of health and Long Term Care, October 2014.

Figure 1: A Holistic Approach to Enhanced Activation



Unique Principles

Patient management, enhanced activation, and all aspects of care will be guided by the following principles:

- as part of enhanced activation and a restorative care approach, services will be based on a model of progressive self-sufficiency to the extent possible. Patients will be encouraged, supported and assisted to do as much for themselves as possible
- patients' daily activities will depend on their abilities, care plan and goals; schedules, activities and programs will be organized around patient and family preferences
- an interprofessional team with expertise in geriatric care will work collaboratively with patients and family to attain goals. Goals such as increasing physical activity will not be considered solely as a role for physiotherapy but rather, a focus for the entire care team
- family and other informal caregivers will be partners in the care of patients and involved in care planning and key treatment decisions, with opportunities to participate in scheduled activities and activation therapy.

Goals of the Program

In designing an approach to enhanced activation, it is important to consider the range of functional and cognitive abilities that may exist within the ALC patient population. ALC patients at the RCC will be within one of two streams

- have restorative potential and the ability to return to life in the community following enhanced activation
- require enhanced activation to maintain function while waiting for a bed in LTC.

Patients in both streams will have a number of health issues, which may include:

- physical frailty and geriatric issues such as memory impairment, continence issues and fall risk/ambulation challenges
- chronic disease
- dementia
- mental health challenges

The strategy for enhanced activation at the RCC will be individualized for each patient's level of physical, cognitive and functional ability. When designing activities for enhanced activation the immediate goals of each patient, which are determined by longer term goals and discharge destinations, will be considered:

- Patients waiting for a place in LTC may have goals, including
  - optimizing functional and cognitive ability
  - preventing deconditioning, delirium and other adverse outcomes such as falls, skin breakdown and adverse drug reactions.
- Patients planning to return to the community with supports may have goals, including
  - enhancing or regaining functional ability (focus on activities of daily living, mobility and cognition)
  - regain independence so that care needs may be met in the community.

While designing enhanced activation programming, the partner hospitals considered patients in both streams with a diverse range of health challenges.

Assessment and Care Planning

While screening and assessment protocols and specific eligibility criteria have yet to be developed, the partner hospitals have identified care requirements that will not be accommodated in the RCC due to the constraints of the existing facility. They include

- the provision of enhanced access facilities and bariatric equipment or furnishings for morbidly obese patients
- the provision of a unit that is secure for patients with challenging behaviours who are at risk of wandering and cannot be monitored using other means.

Prior to arrival at the Finch site, each partner hospital will conduct a comprehensive assessment of patients' physical, functional, cognitive, communicative and psychosocial capabilities to determine care requirements, goals, expected length of stay and to identify and plan for anticipated challenges regarding discharge.

Patient progress will be regularly reviewed at weekly interprofessional rounds. Care plans will be adjusted accordingly by the ALC unit teams.

ALC unit teams will collaborate with home and community care services to coordinate care and facilitate discharge to alternative settings, such as long term care, assistive living or home. Care coordination services and activities will include:

- reassessing patients' eligibility for service and arrange service plans
- identifying patients not presently active with Home and Community CLHIN to ensure the appropriate destination and level of care for a safe transition from Finch ALC unit into community
- collaborating with the unit team to address hospital flow pressures from the originating hospital sites for patient transfers to the Finch ALC unit
- assisting patients and family with system navigation by providing information and linkages to community resources to complement Home Care services
- providing information to patient and families on alternative living options which may include Home First, Convalescent Care, Long Term Care, Retirement Homes and assistive/supportive housing
- assisting in future planning and safe transitioning to alternate levels of care
- authorizing services based on patient needs using clear and time measured goals to meet the required outcomes for the patient as per service guidelines and within limits of available resources
- reviewing LTC application time lines and update the standardized assessment (RAI HC) every 3 months for patients waiting for Long Term Care Placement

- maintaining regular contact with patient/family
- providing updated assessments as requested, as well as obtaining additional medical information required by the Long Term Care Home to facilitate appropriate bed matches within tight deadlines
- responding to Bed Offer information and ensuring patient stability for transfer prior to presenting Bed Offer to patient/family; providing additional counselling about remaining choices and prioritization.
- notifying the unit team of Bed Offer acceptance to enable timely transportation and discharge arrangements.

Program Evaluation

It is anticipated that this project will contribute to improving timely transitions and the flow of patients among different levels of care in the Central LHIN. Accordingly, at a system level, the project aims to reduce ALC utilization and will be tracked using the outcome indicators identified in Figure 2.

Figure 2: ALC Outcome Indicators

Indicator	Target Measure
Reduction in Acute LOS for cohort of patients that have been identified as "high risk" for ALC designation	FY 2017-18 = 6.6% FY 2018-19 = 6.6%
Reduction in Post-Acute LOS	FY 2017-18 = 2.1% FY 2018-19 = 2.1%
Reduction in % ALC Days	FY 2017-18 = 2.0% (ALC Rate = 14.2%) FY 2018-19 = 8.3% (ALC Rate = 13.1%)
Decrease number of patients waiting for Long-Term Care	FY 2017-18 = 12.0% FY 2018-19 = 12.0%
Decrease in 90th percentile LOS for patients designated Home with CCAC Services, Rehabilitation, Convalescent Care, Complex Continuing Care and Palliative Care	FY 2017-18 = 3.1% FY 2018-19 = 3.1%

Source: Discharge Planning Dashboard Project, HRH.

Specific outcome measures for the RCC ALC program have not been identified at this point in time. The partner hospitals in collaboration with the Central LHIN will continue to develop the model of care including a plan for evaluating program outcomes. It is anticipated that standardized assessment tools such as the RAI-HC will be used to provide comparative measures of patient progress and functional improvement.

Enhanced Activation Programming

Scope of Services

The partner hospitals collaboratively developed a staffing model for the ALC units for inclusion in the modified Stage 1 and 2 submission. Each ALC clinical team will include:

- a nurse practitioner
- registered nurses
- registered practical nurses or personal support workers
- a pharmacist/technician
- a part-time dietitian
- a social worker
- a part-time occupational therapist
- physiotherapists
- rehabilitation assistants
- a part-time speech language pathologist
- recreation therapists
- a hospital care coordinator from Home and Community Care

Teams on each unit will also include management and administrative staff and volunteers. Volunteers will receive specialized training supported by Hospital Elder Life Program (HELP) materials to assist with

- social and recreation activities
- feeding
- daily orientation
- early mobilization

Adult and youth volunteers may also provide friendly visiting services and accompany patients to other parts of the facility when participating in centre-wide activation programming.

In addition to services provided by each professional discipline on the ALC unit team, enhanced activation will be provided using a collaborative, interprofessional approach. Key elements will include the following:

Mobilization – enhanced activation will include early and consistent mobilization for all patients. Mobilization programs will aim to increase patients' strength and tolerance, which will decrease the risk of falls and support optimal function in daily activities. Activities may include specific exercise programs or movement associated with other activities such as gardening or congregate dining. Patients will be encouraged and supported to engage in physical activity, at a minimum, twice daily, seven days a week, with or without the use of mobility aids (wheelchairs, walkers) or a geriatric chair.

Activation through social and cognitive programming – a diverse range of activities and interventions will be provided on an individual and group basis to engage patients socially and address feelings of loneliness, boredom and loss. Activities will be designed to promote social interaction but respect patient choice, values and cultural diversity. Individual cognitive therapy, use of sensory carts and groups using modalities such as music, creative arts and storytelling can provide both cognitive and social stimulation. The partner hospitals will explore opportunities to incorporate information and communication technology such as tablets to augment programming.

In addition to on-unit activities, centre-wide activation programming will be available for all patients and include music, social and seasonal events or celebrations.

Behavioural management – specific strategies and programming will be implemented to support patients exhibiting responsive behaviours due to dementia or other brain diseases. The RCC program will be supported by the Central LHIN Behavioural Support Transition Resource (BSTR) team to

- develop comprehensive behavioral care plans
- liaise with family, community care providers and LTC staff to coordinate effective transitions from the RCC to an alternate level of care
- provide education and training for ALC unit teams.

Senior friendly hospital care[2]– care processes that specifically address issues common to hospitalized seniors will be implemented. Protocol and metrics will address

- falls
- pressure ulcers
- adverse drug reactions
- restraint use
- sleep management
- continence
- hydration and nutrition
- dementia related behaviour.

Functional decline and delirium, which are liked to other potentially adverse outcomes, will be assessed and closely monitored.

[2] Wong, K., Ryan, D. and Liu, B. Senior Friendly Hospital Care Across Ontario, Summary Report and Recommendations, 2011.

Spiritual care – spiritual health will be a distinctive and vital component of holistic care at RCC by respecting patients' various religious beliefs, traditions and community/cultural backgrounds. Spiritual care services will be provided by each partner hospital and augmented by visiting chaplains. Services will include multi-faith worship and spiritual/emotional support through visitation and counselling.

Enabling Components of Care

In addition to restorative care, a number of other supports are required to ensure patients benefit from an enhanced model of activation. Enabling components of the care plan are outlined below.

Care coordination and transition planning will be key components of the ALC program at the RCC. Care teams will collaborate with Home and Community Care services to coordinate care and facilitate discharge to alternative settings, such as long term care, assistive living or home with supports. Social workers and care coordinators will work with patients and their families to assess existing barriers to discharge, assist in communicating with other healthcare providers, navigate the health system, and identify relevant community programs. Potential services may also include discharge trials and a Home and Community Care pre-discharge home visit.

Caregiver support and involvement throughout the care process is beneficial in reducing patient confusion and improving adherence to care plans, especially following discharge. Caregivers will be encouraged to maintain an active role in the care of their loved one at the RCC, and alternative solutions such as virtual visits through Skype will be implemented for caregivers/families who may not be able to visit their loved one on a regular basis. The enhanced activation program will also support and educate caregivers who may feel overwhelmed by their role as an informal caregiver. Barriers to discharge often include caregivers' hesitation and feelings of being unprepared for the demands of providing care. The RCC will provide caregivers with the opportunity to participate in enhanced activation. Family members will observe their loved one's progress with regards to mobility and functional capability as reassurance that care can be managed in the community context.

Disease management education is an important component of any transitional care program. Disease management education empowers patients to take an active role in their own care. Education will be especially valuable for patients who may return to living in the community following discharge from the RCC.

Advance care planning will be initiated or updated on the ALC unit. Patients and family, particularly substitute decision makers if determined, will meet with a member of the care team to discuss patients' values and wishes regarding care if they are unable to speak for themselves. Advance care planning may occur prior to transfer to RCC, however, plans will be reviewed upon admission to the ALC unit.

Activities and Interventions

Working group sessions identified a number of organized and informal activities and exercises that may contribute to the maintenance or restoration of functional abilities and well being. These activities are outlined in Figure 3 below.

Figure 3: Activities for Enhanced Activation

Mobilization	Social/Cognitive Programming		Spiritual Health
• group exercise sessions • mobilization activities (twice daily) • falls prevention training • ADL training • wheel chair exercise classes • dance and movement therapy • yoga • Tai Chi • indoor and outdoor walking routes • horticultural activities	• music and art therapy • musical concerts and/or vocalists/choirs • cognitive therapy • doll therapy • music and memory playlists • pet therapy • seasonal and holiday gatherings • intergenerational events • horticultural activities • BBQ's and other outdoor events	• cooking and baking activities • writing groups and oral presentations • drama groups • individual cognitive therapy • seasonal and holiday gatherings • sensory activities, snoezelen carts • congregate dining • movie night • games - computer or board • storytelling	• multi-faith celebrations • counselling services • spiritual group sessions • meditation

Ethel's Journey

The journey of a fictional persona named "Ethel" is described below to illustrate the experience of a patient who is initially admitted to an acute care unit and subsequently requires an alternate level of care following resolution of the acute episode. It is included to provide a more personal view of who may be admitted to the RCC and expectations on how they will positively experience the Centre.

Figure 4: Introducing Ethel

Source: baycrest.org

Name: Ethel

Age: 86

Marital Status: Widowed

Reason for Admission into Acute Care: Flu

Physical Status: Frail, ambulates with a walker

Cognitive Status: Declining; no dementia identified

A former school teacher, Ethel retired in 1996 to spend more time with her family. Unfortunately, things took a turn for the worst when her husband was diagnosed with Alzheimer's disease in 1997. Ethel spent ten years caring for her husband until he passed due to complications related to pancreatic cancer in 2007.

Since her husband's passing, Ethel's physical condition has steadily declined. She has moved out of her home, opting to rent a small apartment closer to her daughter, Beth. Her favorite part of the week is when her daughter comes to visit on Saturday with Ethel's grandson. Although Ethel maintained close relationships with her friends early in her retirement, she spends most of her time alone in her home as their social gatherings have slowly become less frequent.

On one of their visits in 2017, Ethel's daughter noticed that Ethel seemed to have a cough, in addition to mentioning unusual achiness and discomfort. When Beth offered to take Ethel to the doctor, Ethel insisted she had a minor cold and refused to seek medical attention. Three days later, Ethel was rushed to hospital when Beth discovered her mother experiencing difficulty breathing and some mental confusion.

Ethel spent three weeks in the hospital before recovering from the flu. When it became time to plan for discharge, it was obvious that Ethel had experienced such physical deterioration that she would not be able to return home. Hopeful at first, it was determined that Ethel was not a candidate for rehabilitation. She remained in acute care as an ALC patient, where she slowly became demotivated and depressed.

Then, one day, Ethel found out that she might be a candidate for transfer to the Central LHIN Restorative Care Centre.

Day in the Life

Patients transferred to the RCC will have diverse needs. Their daily schedules will vary depending on their unique care plan, goals, preferences and capabilities. While not reflective of every patients' experience, a typical Saturday in the life of "Ethel" is described to demonstrate the anticipated care environment of a RCC inpatient unit. It is included here to illustrate the benefits of the unique model of enhanced activation that will be provided at the Centre. Figure 5 outlines a typical Saturday for an ALC patient at the RCC.

Figure 5: A Saturday in the Life of Ethel

Central LHIN Reactivation Care Centre

6:00 am	Ethel wakes up. A PSW assists Ethel in dressing and walking to the washroom.
8:00 am	Ethel walks, with a walker, to a common dining room for breakfast. She meets three other women her age at her table. They plan to attend movie night together.
10:00 am	Ethel attends a group falls prevention session led by the physiotherapist.
12:00 pm	Using her walker, Ethel walks to a common dining room for lunch and sits with the same group of women she met over breakfast.
2:00 pm	Therapy pets come to visit the unit. The recreation therapist and PSWs help to facilitate visits between patients and pets.
4:00 pm	Ethel calls her daughter on Skype so that they can talk while Beth makes dinner.
6:00 pm	Ethel is tired, but her new friends encourage her to walk to the dining room for dinner.
8:00 pm	Ethel attends movie night. Volunteers (mainly students) help patients travel to the ground floor of the CLRCC and stay to watch the movie and provide refreshments.
10:00 pm	A volunteer helps Ethel back to the unit following movie night. An NP assists Ethel in dressing for bed and walking to the washroom. The unit is quiet as patients return to their rooms, and Ethel is able to fall asleep immediately.

An enhanced staffing model, senior friendly environment and carefully designed and targeted programs are instrumental in creating the patient experience described above. Acute care settings are not designed to accommodate longer term restorative care and typically do not provide the care environment and programming described in this document. The RCC will improve transitions between levels of care, providing patients with an opportunity to restore or maintain function and independence wherever possible, before transitioning to a long term discharge destination.

APPENDIX A – Working Session Notes

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Appendix A – Working Session Notes

Instructions

A large group discussion was facilitated to develop 3 patient personas to characterize the ALC patient population. Participants were separated into 3 separate groups and encouraged to develop a plan for enhanced activation tailored to meet individual needs for each persona.

Group Discussion Part A: Goals for Enhanced Activation

Discharge Destination	Goals for Enhanced Activation
Home	• enhance or regain independence, mobility, cognition • improve ADLs so care needs can be met in the home with some supports • reduce/eliminate incidents of aggressive behaviour
Long Term Care	• optimize functional/cognitive abilities • prevent decline and development of new health issues • reduce/eliminate incidents of aggressive behaviour and reduce need for restraints

Group Discussion Part B: Patient Personas

Group Discussion Part C: Care Plans

Shirley

Source: baycrest.org

- physically frail with multiple comorbidities
- non-weight bearing
- limited resources (financial)
- requires assistance with ADLs and mobility

Anticipated Outcomes

- maintain/enhance functional abilities
- return to living in the community

Supports for Enhanced Activation

- physiotherapy
- occupational therapy
- case management
- recreational therapy
- volunteers
- caregiver involvement

Activities for Enhanced Activation

- informal focus on ADLs
- social events
- music therapy
- falls prevention classes
- smart program (Hamilton Niagara Haldimand Brant Local Health Integration Network)
- activities that involve mobilization including ambulation in the hallway or walks outside where possible (twice a day, if possible)

Wilma

Source: baycrest.org

- cognitive impairment or dementia
- mobile
- has a frail husband who can offer limited support

Anticipated Outcomes

- improve management of behaviours (if present)
- prevent functional or cognitive decline
- discharge to Long Term Care when possible
- reduced length of stay

Supports for Enhanced Activation

- physiotherapy
- case management
- recreational therapy
- volunteers
- caregiver involvement
- transitional care

Activities for Enhanced Activation

- informal focus on ADLs
- discharge trial suite
  - "internal overnight pass"
  - weekend pass trial at home
- Home and Community Care pre discharge visit
- therapist led discussion groups
- group exercise classes
- social events

Gladys

Source: westpark.org

- medical issues with mental health comorbidities and cognitive decline
- mild depression

Anticipated Outcomes

- improve functional and cognitive status
- discharge to community

Supports for Enhanced Activation

- physiotherapy
- case management
- recreational therapy
- volunteers
- caregiver involvement

Activities for Enhanced Activation

- music therapy
- art therapy
- set programming and opportunities for socialization
- cognitive therapy
- focus on ADLs
- physical rehab on individual or group basis
  - mobilization, walk/stairs if able
  - up for meals (on-unit dining room)
- recreational therapy – bingo, games, sing-a-long
- doll therapy
- spiritual care
- video-call with family members