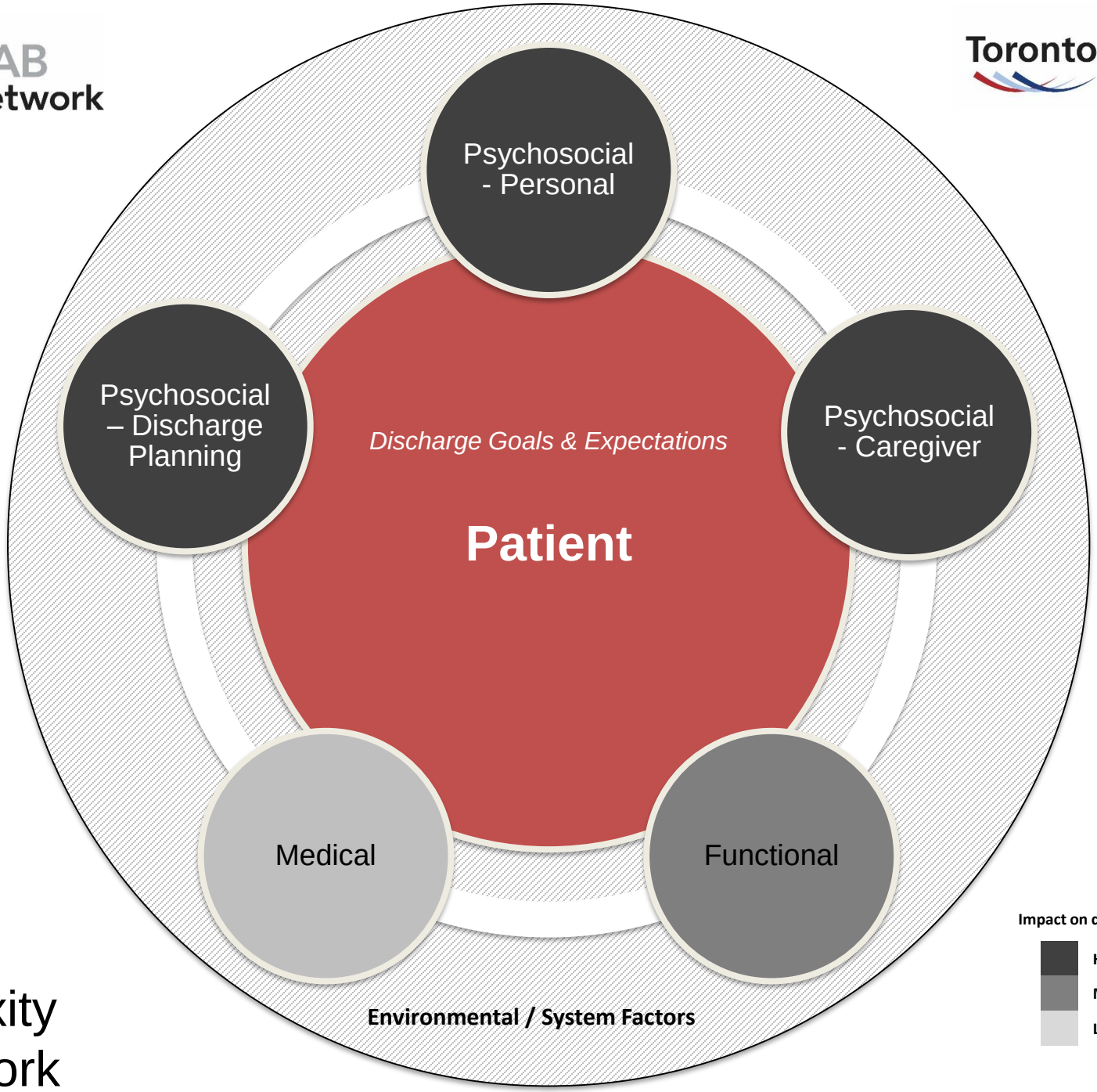
Patient Complexity Framework[1]

PSYCHOSOCIAL - PERSONAL	PSYCHOSOCIAL – DISCHARGE PLANNING	PSYCHOSOCIAL - CAREGIVER	FUNCTIONAL	MEDICAL
Personal characteristics (coping mechanism, high stress/anxiety levels, mood, motivation, etc.)	Challenging home situation: physical (homelessness, inadequate/poor housing)	Lack/limited social supports	Mobility/ADL/IADL needs that cannot be met by current support systems (e.g., falls, weight-bearing status, incontinence)	Specialty medical equipment needs (e.g., bariatric support, ventilator, hemodialysis, CPAP)
Social history (addiction, mental health issues, hoarding, legal/criminal)	Environmental barriers of discharge destination (e.g., infection control requirements, physical environment)	Caregiver burden and family relationships/ dynamics	Behavioural issues requiring specific management strategies (e.g., need for a sitter, locked unit or psychiatry support)	Multiple complex medical care needs requiring treatment at a high frequency and set multiple timeframes (e.g., tube feeds, suctioning, turning, cancer treatment)
Risk to self or others	Lack of discharge destination		Cognitive impairment / delirium / dementia	≥ Stage 2 pressure ulcer(s) and complex wound care needs
High intensity social service utilization	Socioeconomic status (e.g., no OHIP coverage, available financial resource)		Communication issues due to - Aphasia - English as a second language barrier - Hearing impairment	Complex medical regimes and/or polypharmacy
Role of patient (e.g., as caregiver)			Pre-existing conditions affecting function (e.g., visual impairment)	

1. Based on the Integrated funding model – Stroke project 2016-2017, the GTA Rehab Network Transitions 2013 Initiative, and referral triggers - TC LHIN ALC transition team 2012, Think Tank: Understanding complexity of patients post-hip fracture and stroke 2017.



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