Rehabilitative Care Alliance

Overview of the Definitions Framework for Rehabilitative Care

Background:

The mandate of the Definitions Task Group is to develop standardized definitions that describe rehabilitative care resources across the continuum, including a system-wide Assess and Restore approach.* The first phase of this work focused on the development of the Definitions Framework for Bedded Levels of Rehabilitative Care. The second phase has focused on the development of standardized definitions for community-based levels of rehabilitative care. These frameworks together serve as foundational documents that define (1) the levels of rehabilitative care across the continuum and (2) the recommended standard components and human resources within each level of rehabilitative care. While there is recognition that the framework is not population-specific and that the specialized tertiary services provided by some Health Service Provider organizations are beyond the resource thresholds described within the framework, the framework can be used by LHINs as part of a capacity planning process to evaluate rehabilitative care resources within the context of specific patient and local/regional programming needs. This work has been informed by consultations with rehabilitative care providers across the province and nationally as well as an extensive review of the literature, including rehabilitation programs/centres in Canada and elsewhere.[1]

The objectives in developing a provincial Definitions Framework are to:

- Establish provincial standards for rehabilitative levels of care across the continuum of care
- Provide clarity for patients, families and referring professionals on the focus and clinical components of rehabilitative care programs
- Provide a foundation to support system and local capacity planning through a common understanding of rehabilitative care services

The following principles and definition of rehabilitative care underpin the Definitions Framework:

- Solutions developed by the Definitions Task Group will:
  - be developed from the patient's/client's perspective
  - maximize resource utilization
  - standardize and streamline system processes (e.g. eligibility, data collection)
- Definition of rehabilitative care:[2]
  - It is delivered in homes, community based locations, long term care homes and hospitals.
  - People may require rehabilitative care as a result of illness, injury, lifelong disability, chronic disease, or degenerative condition.
  - It incorporates a broad range of interventions that address one or more of medical/clinical care needs, therapeutic needs, and/or psycho-social needs.
  - The desired outcomes of rehabilitative care will include one or more of maintenance or sustaining of functionality[3], restoration of functionality and/or development of adaptive capacity
- Family/significant others are recognized as key to enabling patient/client function and attainment of goals and are involved throughout the rehabilitative care process:
  - Families/caregivers, with patient/client consent, are included in discussions around key treatment decisions
  - Families (and patients/clients) are encouraged to participate in team meetings
- Goals and plans are developed from the patient's perspective and in concert with families/caregivers, with patient/client consent.

* An Assess and Restore approach refers to Assess and Restore *interventions* that are provided to a defined population of high-risk, frail seniors who have experienced a recent loss of functional ability following a medical event or decline in health; are at high risk for imminent hospitalization or admission into a long-stay Long-Term Care (LTC) home bed as a result of that functional loss; and who have restorative potential, i.e., they have the potential to regain that functional loss so that they are no longer at high risk. These interventions are delivered within and across a range of existing programs and levels of care, including but not limited to the bedded levels of rehabilitative care described in this framework.

Definitions Framework for Community–Based Levels of Rehabilitative Care

The Definitions Framework for Community-Based Levels of Rehabilitative Care represents the second phase of the Definitions initiative and has been drafted with input from committee members of the Definitions Task and Advisory Groups and the LHIN Leads/Health Service Providers Advisory Group, each of which include medical, clinical and administrative stakeholders from across organizations and LHINs.

The objectives in developing a Definitions Framework for Community-Based Levels of Rehabilitative Care are to support:

- Clarity for patients/clients, families and referring professionals on the community-based levels of rehabilitative care through definitions for each level that describe goals for levels of care; target populations; medical and healthcare professional resources; and the overall focus and underlying principles of therapy services provided in the community
- Appropriate/efficient use of rehabilitative care system resources through the description of resources within each level of community based rehabilitative care
- An understanding of current state resources to inform capacity planning

The *scope* of the definitions within this framework includes publicly-funded rehabilitative care programs (i.e. LHIN or MOHLTC funded) provided by or under the supervision of regulated health professionals with a primary rehabilitative care focus to improve function and maintain/prevent functional decline.*

***Note:** While wellness focused health promotion/prevention programs that are not provided by or supervised under regulated health professionals are beyond the scope of the Definitions Framework for Community Levels of Rehabilitative Care, it is acknowledged that such programs play an important role in the system by promoting overall health and supporting patients' reintegration into the community. Examples of these programs include: Group exercise; wellness promotion classes; swimming; walk-fit; yoga; Tai-Chi; Pilates; peer support and friendly visiting programs.

Eligibility Criteria for Community-Based Rehabilitative Care

The community-based levels of rehabilitative care within this framework are to be applied to patients/clients who meet the following eligibility criteria:

- The patient/client has restorative potential*, (i.e. There is reason to believe, based on clinical assessment and expertise and evidence in the literature where available, that the patient's/client's condition is likely to undergo functional improvement and benefit from rehabilitative care) or s/he requires rehabilitative care to prevent functional decline *and*
- The patient/client is medically stable enough such that s/he is able to participate in and benefit from rehabilitative care (i.e., carry-over for learning) within the context of his/her specific functional goals; *and*
- The patient/client has identified goals that are specific, measurable, realistic and timely.

*Restorative Potential

Restorative Potential means that there is reason to believe (based on clinical assessment and expertise and evidence in the literature where available) that the patient's/client's condition is likely to undergo functional improvement and benefit from rehabilitative care. The degree of restorative potential and benefit from the rehabilitative care should take into consideration the patient's/client's:

- Premorbid level of functioning
- Medical diagnosis/prognosis and co-morbidities (i.e., is there a maximum level of functioning that can be expected owing to the medical diagnosis /prognosis?)
- Ability to participate in and benefit from rehabilitative care within the context of the patient's/client's specific functional goals and direction of care needs

Note: Determination of whether a patient/client has restorative potential includes consideration of all three of the above factors. Cognitive impairment, depression and delirium should not be used in isolation to influence a determination of restorative potential.

Rehabilitative Care Alliance

CONCEPTUAL DEFINITIONS FRAMEWORK FOR COMMUNITY LEVELS OF REHABILITATIVE CARE

These definitions pertain to publicly-funded programs (i.e. LHIN or MOHLTC funded) with a primary rehabilitative care focus provided by or under the supervision of regulated health professionals.

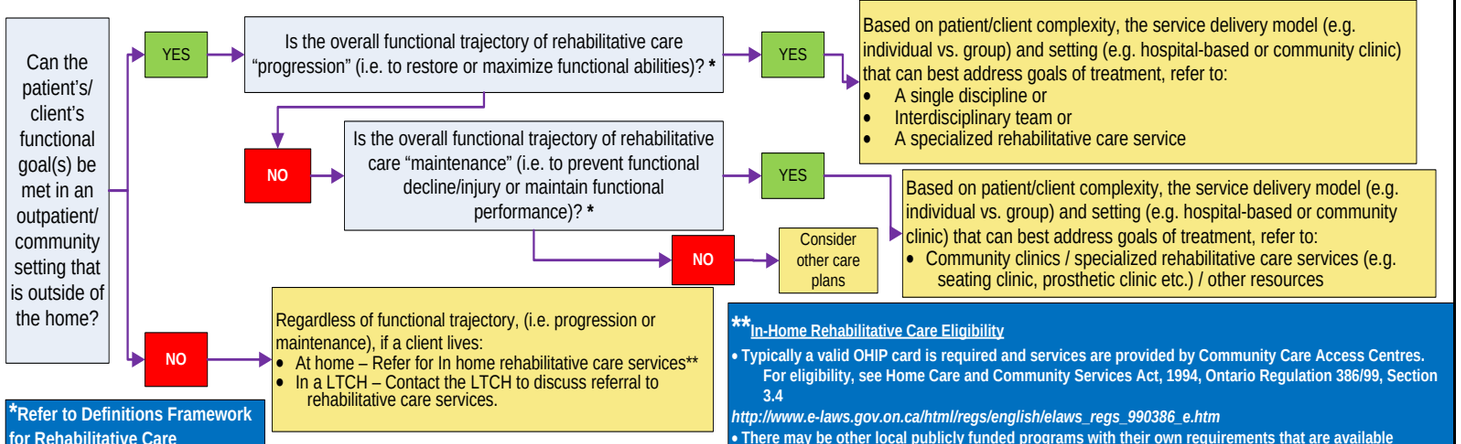
Part A: Determine which level of community-based rehabilitative care would meet the needs of the patient/client

Functional Trajectory		Progression	Maintenance
Level of Care - Goal			
Patient Characteristics	Target Population / Functional Characteristics		
	Transition Indicator		
Medical / Healthcare Professionals	Medical Care		
	Nursing/Therapy Care		
Reporting Tools			

Wellness/Health Promotion Post-Rehabilitation Community Reintegration*

- Wellness/health promotion programs provided by non-regulated health professionals * after illness/injury to halt/slow disease process, help individuals manage health problems and to support community re-integration
- These programs should be considered by providers within the defined levels of rehabilitative care when discharge planning and transitioning clients to self-management activities.

Part B: Determine location of community-based rehabilitative care



*Note: While wellness focused health promotion/prevention programs that are not provided by or supervised under regulated health professionals are beyond the scope of the Definitions Framework for Community Levels of Rehabilitative Care, it is acknowledged that such programs play an important role in the system by promoting overall health and supporting patients' reintegration into the community. Examples of these programs include: Group exercise; wellness promotion classes; swimming; walk-fit; yoga; Tai-Chi; Pilates; peer support and friendly visiting programs.

DEFINITIONS FRAMEWORK FOR COMMUNITY LEVELS OF REHABILITATIVE CARE

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Part A: Determine which level of community-based rehabilitative care would meet the needs of the patient/client

Functional Trajectory		**PROGRESSION**[4]	**MAINTENANCE**
Level of Care - Goal		• Rehabilitation is focused on enabling individuals with impairments and disabilities to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels and thereby promote health and well-being, re-integration to community living and improve quality of life.[5 6 7 8] • Determination of where the client receives community-based rehabilitative care is based on which environment would be best suited to achieve the client's rehabilitative care goals including consideration of resource/equipment needs, individual vs. group treatment modalities, and the capacity of clients to travel outside of the home.	
		• To provide assessment and time limited treatment through a single service or coordinated, inter-professional approach to: o Restore or maximize functional abilities (including cognitive capacities in all aspects of living) o Promote adaptation of/to the home environment to support re-integration to community and overall quality of life o Support timely transition from or prevent admission to acute care or a bedded level of rehabilitative care o Provide the opportunity to learn and practice in a familiar, stimulating and supportive environment	• To prevent functional decline/injury or maintain functional performance (e.g. strength, mobility, balance, falls prevention etc.) through: o Individual assessment/treatment to address functional impairments, including chronic disease self-management o Periodic assessment and oversight of care plan by regulated health professional/team to determine the need for engagement of additional rehab professionals depending on client need and availability of family support or informal care networks
Patient Characteristics	*Target Population / Functional Characteristics*	• Individuals who following acute episodes or the worsening of symptoms due to a debilitating event or progressive condition including chronic disease, pain, injury or surgical procedure:[9] o Have functional impairments resulting in decreased function (e.g. reduced functioning in ADLs, mobility, communication, cognition, swallowing or mobility etc.) o Require rehabilitation to achieve functional goals, increase self-management skills and maximize community reintegration o Do not require a bedded level of care	• Individuals with reduced physical/cognitive/speech-language functioning (e.g. neuromuscular, musculoskeletal and cardio-respiratory etc.) who require rehabilitative care to prevent a decline in functional status and/or to promote their capacity to remain at home. • Individuals living in the community (home, retirement homes, LTCHs) who have functional goals that can be met by participating in group intervention, which could include falls prevention classes.[10]
		Note: Some individuals, for example those who are aging with a chronic disability where a decline might be anticipated due to the nature of their health condition, may need to move between the maintenance and progression levels of rehabilitative care in the event that a new functional goal and treatment plan is identified (e.g. a client with Multiple Sclerosis developing the need for an Ankle Foot Orthosis or an aging client with paraplegia who develops shoulder osteoarthritis from years of transfers).	

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Part A: Determine which level of community-based rehabilitative care would meet the needs of the patient/client

Functional Trajectory		PROGRESSION[4]	MAINTENANCE
	Transition Indicator	Determined by the following considerations: • When individuals have achieved their identified therapeutic objectives / functional goals as per the client's treatment plan *or* • Reasonably equivalent gains can be achieved independently or with the assistance of a caregiver at home or through self-care or wellness/health promotions classes (e.g. exercise classes)[11] or other appropriate resources in the community *or* • No further gains are likely to be achieved (i.e. a plateau has been reached)	Determined by the following considerations: • When individuals have achieved their identified therapeutic objectives / functional goals as per the client's treatment plan to prevent decline in function *or* • Reasonably equivalent gains can be achieved independently or with the assistance of a caregiver at home or through self-management or wellness/health promotions classes (e.g. exercise classes)[12] or other appropriate resources in the community • Individuals have the opportunity to transition back into the Maintenance level if intermittent assessment and/or intervention are needed. • Individuals may transition to the Progression level of community-based rehabilitative care or to a bedded level of rehabilitative care to address the onset of a new condition or change in treatment plan
		Note: At each transition point, mechanisms for the coordination and communication of the post-discharge rehabilitative care plan with the receiving provider(s) and patient and families/caregivers should be in place to support a successful transition. [13]	
Medical / Healthcare Professionals	***Applicable to both Medical and Healthcare Professionals***	Rehabilitative care provided by medical, nursing and allied health providers: • Is client-centred[14] and based on the client's assessed care needs and goals • Includes a written plan of care for each person receiving the service • Is coordinated and uses a collaborative model of care where there are mechanisms in place to support effective case coordination/management and communication among all members of the rehabilitative care team and the primary care practitioner • Involves the client, family and/or informal caregivers in care planning, with the client's consent	
	Medical Care	Medical care/management may be provided by a primary care practitioner (e.g. Family Physician, Nurse Practitioner) as well as by those focused on rehabilitative care (e.g. physiatrists, geriatricians, paediatricians and/or other specialists)	
	Healthcare Professionals	• Therapy services: o Are provided by or under the supervision of a minimum of one regulated health professional or by an integrated, inter-professional team of regulated health professionals (if more than one discipline is required) with expertise in the condition(s) for which the client is being treated as well as some understanding of associated pre-morbid conditions. • Some programs may use therapy assistants under the supervision of a regulated health professional (e.g. PT or OT assistants) as part of the care team to increase the impact, intensity, adherence and supervision of therapy. [15] • Regulated health professionals may include but are not limited to: Physiotherapists, Occupational Therapists, Speech-Language Pathologists, Social Workers, Registered Nurses, Dietitians, Psychologists, Chiropodists, and Kinesiologists o May include interventions to improve: ADL; communication; cognition; swallowing; balance; lower /upper extremity strength; mobility; ability to transfer/move in bed; functional transfers; seating and positioning; behaviours; safety; adaptive equipment; coping including emotional functioning and adjustment to disability; independence and return to vocational activities o May be primarily consultative or assessment-based for assistive devices needs (e.g. seating clinics & Assistive Devices Programs; Augmentative Communication	

<table>
<tr><th colspan="3">DEFINITIONS FRAMEWORK FOR COMMUNITY LEVELS OF REHABILITATIVE CARE
These definitions pertain to publicly-funded programs (i.e. LHIN or MOHLTC funded) with a primary rehabilitative care focus provided by or under the supervision of regulated health professionals.</th></tr>
<tr><th colspan="3">Part A: Determine which level of community-based rehabilitative care would meet the needs of the patient/client</th></tr>
<tr><th colspan="2">Functional Trajectory</th><th>PROGRESSION[4]</th><th>MAINTENANCE</th></tr>
<tr><td rowspan="3"></td><td rowspan="2">Healthcare Professionals</td><td colspan="2">Clinics) or to address other impairments or disability (e.g. Spasticity Clinic; Vocational Rehab; Geriatric Assessment; Follow-up appointments following discharge)
o May be provided in individual or group format
o May include rehab groups that are led by a regulated rehab professional or team of regulated health professionals to enhance an individual's ability to cope with impairments, activity limitations and participation restrictions.[16]</td></tr>
<tr><td>• In the Progression level, therapy services:
o Are provided to improve, develop or restore function lost or impaired as a result of de-conditioning, a health condition, pain, injury or surgical procedure
o May include intensive rehabilitation to support early discharge from hospital or to prevent admission to hospital</td><td>• In the Maintenance level, therapy services:
o Are provided to maintain and/or to prevent a decline in functional/clinical status as a result of de-conditioning, a health condition, pain or aging
o May involve intermittent re-assessment/treatment and/or periodic oversight by regulated health professional/team to determine need for engagement of additional rehab professionals depending on client need and availability of family support or informal care networks
• May include falls prevention group classes or other wellness/health promotion classes provided by a physiotherapist or other regulated health professional.
• In order to align with best practices, fall prevention programs should be comprehensive,[17] multi-factorial [18,19,20] and may include but are not limited to the following components:
o Individualized risk assessment:[21] A brief risk assessment can be used to identify those who require a more comprehensive evaluation based on risk factors[22] and geriatric syndromes. Such assessments may include a review of environmental hazards, including the home;[23,24] vision screening[25]; medication management[26]; continence; nutritional assessment[27] and other risk factors.
o Exercise: Exercise programs have been shown to reduce the risk of fall recurrence[28].[29] These programs include strength training;[30,31]balance training[32,33]; gait training[34]; and advice on the appropriate use of assistive devices.[35]
o Education: Education with clients, caregivers and providers is recommended as part of a comprehensive approach. It is important to recognize, however, that education alone does not reduce the risk of falls[36,37,38]. Topics covered through educational efforts may include: improving environmental safety, how to safely change positions, managing weather conditions, and reducing fear of falling, among others.</td></tr>
<tr><td>Therapy Intensity</td><td colspan="2">o The number and frequency of services are based on the treating therapist's assessment, evidence-based best practices and the client's individual needs.</td></tr>
<tr><td colspan="2">Reporting Tools</td><td colspan="2">Recommendations regarding a common data set are currently underway by the RCA Outpatient/Ambulatory Task Group</td></tr>
</table>

DEFINITIONS FRAMEWORK FOR COMMUNITY LEVELS OF REHABILITATIVE CARE

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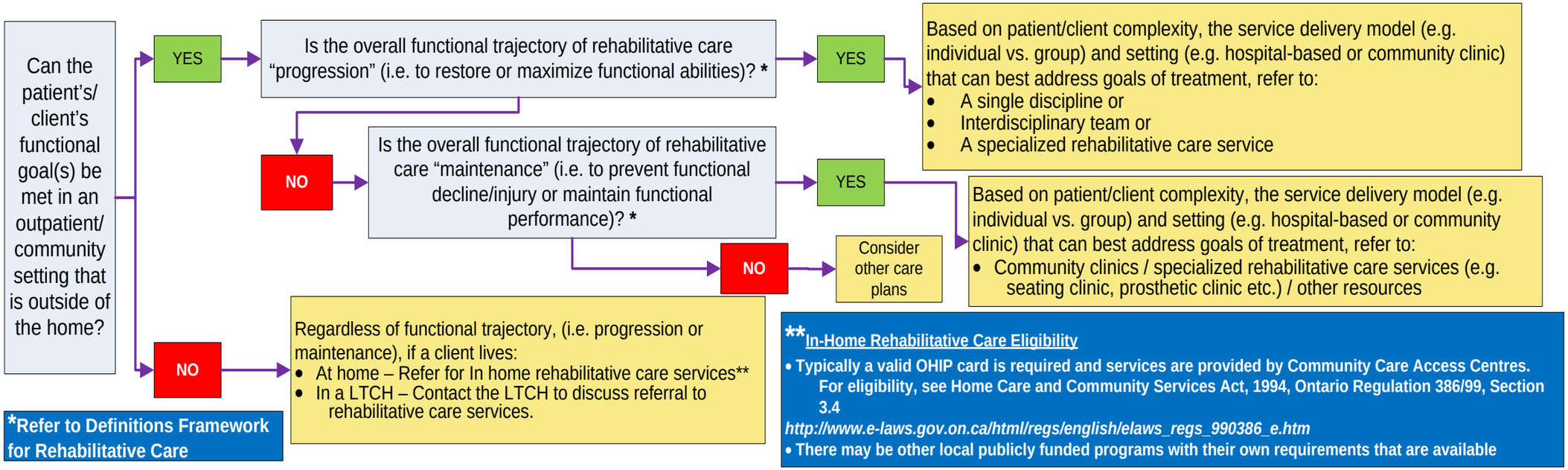
Part B: After determining which level of community-based rehabilitative care is needed, refer to the decision tree below to determine location of community-based rehabilitative care

Referral Decision-Making Tool for Determining Location of Community-Based Rehabilitative Care



Endnotes

[1] See Definitions Task Group Backgrounder Document, October 2013. http://rehabcarealliance.ca/uploads/File/Toolbox/Definitions_Task_Group_BackgrounderFINAL.pdf
[2] Rehabilitative Care Conceptual Framework. Developed by Definitions Working Group for the Rehabilitation and Complex Continuing Care Expert Panel. Nov 2011.
[3] The concept of functionality is derived from the WHO/World Bank "World Report on Disability, 2011" which describes functioning as: "An umbrella term in the ICF for body functions, body structures, activities, and participation. It denotes the positive aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).
[4] Community-based education programs such as group exercise, activation, or falls prevention classes or services provided solely to maintain an existing level of function are not included within this level of care.
[5] To provide assessment and treatment(s) to improve, develop or restore physical function and/or to promote mobility. Ontario Association of Non-Profit Home and Services for Seniors. Physiotherapy Clinical Table. "A Guide to Physiotherapy, Occupational Therapy and Exercise Service Provision in Long-Term Care." 2014.
[6] Ontario Ministry of Health and Long-Term Care, Home Care and Community Services Act, 1994, ONTARIO REGULATION 386/99, PROVISION OF COMMUNITY SERVICES
[7] Ontario Ministry of Health and Long-Term Care, Long-Term Care Homes Act, 2007
[8] Ontario Ministry of Health and Long-Term Care, Long-Term Care Homes Act, 2007, Ontario Regulation 79/10
[9] Ontario Ministry of Health and Long-Term Care, Physiotherapy Provider Qs & As Publicly Funded Clinic Based Physiotherapy Services. October 2013.
[10] Waterloo Wellington LHIN. Questions & Answers. WW LHIN Exercise and Falls Prevention Classes Expression of Interest. 2013.
[11] Ontario Association of Non-Profit Home and Services for Seniors. Physiotherapy Clinical Table. "A Guide to Physiotherapy, Occupational Therapy and Exercise Service Provision in Long-Term Care." 2014.
[12] Ontario Association of Non-Profit Home and Services for Seniors. Physiotherapy Clinical Table. "A Guide to Physiotherapy, Occupational Therapy and Exercise Service Provision in Long-Term Care." 2014.
[13] Health Quality Ontario. Adopting a Common Approach to Transitional Care Planning: Helping Health Links Improve Transitions and Coordination of Care. Retrieved from http://www.hqontario.ca/Portals/0/Documents/bp/bp-traditional-care-planning-1404-en.pdf
[14] Patient-centred care has been described as care that is 'respectful of and responsive to individual patient preferences, needs and values' with clinical decisions guided by patient values. See Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century: Committee on Quality of Health Care in America. Washington, D.C: National Academy Press; 2001 cited in Webster, F; Perruccio, A V; Jenkinson, R; Jaglal, S; Schemitsch, E; Waddell, JP; Bremner, S; Mobilio MH; Venkataramanan, V; Davis, A M. Where is the patient in models of patient-centred care: a grounded theory study of total joint replacement patients. BMC Health Serv Res. 2013; 13: 531.; Published online Dec 23, 2013.
[15] In LTCHs, occupational therapy and speech-language therapy are provided by regulated health professionals and/or by "support personnel who are members of the staff of the Home who work under the direction of a member of the appropriate regulated health profession and the designated lead of the restorative care program; and social work/social services work Ontario Ministry of Health and Long-Term Care, A Guide to the Long-Term Care Homes Act, 2007 and Regulation 79/10, Sections 59, 61 and 62.
[16] World Health Organization. Towards a Common Language for Functioning, Disability and Health: ICF The International Classification of Functioning, Disability and Health International Classification of Functioning, Disability and Health (ICF). http://www.who.int/classifications/icf/en/
[17] Moreland, J., Richardson, J., Chan, D.H., O'Neill, J., Bellissimo, A., Grum, R.M. and Shanks, L. (2003). Evidence-based guidelines for the secondary prevention of falls in older adults. Gerontology, 49, 93-116
[18] World Health Organization. (2007). WHO Global Report on Falls Prevention in Older Age. Geneva, Switzerland: WHO Press.
[19] Moreland, J., Richardson, J., Chan, D.H., O'Neill, J., Bellissimo, A., Grum, R.M. and Shanks, L. (2003). Evidence-based guidelines for the secondary prevention of falls in older adults. Gerontology, 49, 93-116.
[20] World Health Organization. (2007). WHO Global Report on Falls Prevention in Older Age. Geneva, Switzerland: WHO Press.
[21] Moreland, J., Richardson, J., Chan, D.H., O'Neill, J., Bellissimo, A., Grum, R.M. and Shanks, L. (2003). Evidence-based guidelines for the secondary prevention of falls in older adults. Gerontology, 49, 93-116.
[22] Public Health Agency of Canada. (2005). Report on Seniors Falls in Canada. Retrieved March 17, 2009 from http://www.phac-aspc.gc.ca/seniors-aines/pubs/seniors_falls/pdf/seniors-falls_e.pdf
[23] Moreland, J., Richardson, J., Chan, D.H., O'Neill, J., Bellissimo, A., Grum, R.M. and Shanks, L. (2003). Evidence-based guidelines for the secondary prevention of falls in older adults. Gerontology, 49, 93-116.
[24] Moreland, J., Richardson, J., Chan, D.H., O'Neill, J., Bellissimo, A., Grum, R.M. and Shanks, L. (2003). Evidence-based guidelines for the secondary prevention of falls in older adults. Gerontology, 49, 93-116.
[25] Public Health Agency of Canada. (2005). Report on Seniors Falls in Canada. Retrieved March 17, 2009 from http://www.phac-aspc.gc.ca/seniors-aines/pubs/seniors_falls/pdf/seniors-falls_e.pdf
[26] Moreland, J., Richardson, J., Chan, D.H., O'Neill, J., Bellissimo, A., Grum, R.M. and Shanks, L. (2003). Evidence-based guidelines for the secondary prevention of falls in older adults. Gerontology, 49, 93-116.
[27] World Health Organization. (2007). WHO Global Report on Falls Prevention in Older Age. Geneva, Switzerland: WHO Press.
[28] Moreland, J., Richardson, J., Chan, D.H., O'Neill, J., Bellissimo, A., Grum, R.M. and Shanks, L. (2003). Evidence-based guidelines for the secondary prevention of falls in older adults. Gerontology, 49, 93-116.

[29] Recent research indicates that group-based exercise is effective for falls prevention, quality-of-life enhancement, and balance improvements in the older adults comparable with traditional home exercise programs. See Martin JT, Wolf A,Moore JL, Rolenz E, DiNinno A, Renneker, JC. (2013). The effectiveness of physical therapist-administered group-based exercise on fall prevention: a systematic review of randomized controlled trials. J Geriatric Physical Therapy. Oct-Dec; 36(4):182-93.

[30] Vogler, C.M., Sherrington, C., Ogle, S.J., and Lord, S.R. (2009). Reducing the risk of falling in older people discharged from hospital: A randomized controlled trial comparing seated exercises, weight-bearing exercises, and social visits. *Archives of Physical Medicine and Rehabilitation, 90,* 1317-1324.

[31] American Geriatrics Society (AGS) Panel on Falls in Older Persons. (2001). Guideline for the Prevention of Falls in Older Persons. Journal of the American Geriatrics Society, *49,* 664-672.

[32] Moreland, J., Richardson, J., Chan, D.H., O'Neill, J., Bellissimo, A., Grum, R.M. and Shanks, L. (2003). Evidence-based guidelines for the secondary prevention of falls in older adults. Gerontology, *49,* 93-116.

[33] American Geriatrics Society (AGS) Panel on Falls in Older Persons. (2001). Guideline for the Prevention of Falls in Older Persons. Journal of the American Geriatrics Society, *49,* 664-672.

[34] American Geriatrics Society (AGS) Panel on Falls in Older Persons. (2001). Guideline for the Prevention of Falls in Older Persons. Journal of the American Geriatrics Society, 49, 664-672.

[35] American Geriatrics Society (AGS) Panel on Falls in Older Persons. (2001). Guideline for the Prevention of Falls in Older Persons. Journal of the American Geriatrics Society, 49*,* 664-672.

[36] World Health Organization. (2007). WHO Global Report on Falls Prevention in Older Age. Geneva, Switzerland: WHO Press.

[37] Public Health Agency of Canada. (2005). Report on Seniors Falls in Canada. Retrieved March 17, 2009 from http://www.phac-aspc.gc.ca/seniors-aines/pubs/seniors_falls/pdf/seniors-falls_e.pdf

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