Rehabilitative Care Alliance

Definitions Task Group Backgrounder Document

October 2013

Table of Contents

CONTEXT

Rehabilitative care is delivered in a wide variety of locations including institutional beds and in the community. There are multiple definitions of rehabilitation and complex continuing care or complex care. These definitions, typically, do not describe changes in patient functional capacity but, rather, locations of care or interventions[1] . The Definitions Task Group of the Rehabilitative Care Alliance will develop provincial standards (i.e. definitions and common terminology), for programs and services across the continuum of care. These provincial standards will provide clarity for patients, families and referring professionals in the focus and clinical components of rehabilitative care programs (including Assess and Restore) and will support the development of a foundation to support local capacity planning for equitable access to rehabilitative care.

This 'Backgrounder' document has been prepared to support the work of the Definitions Task Group of the Rehabilitative Care Alliance in its efforts to develop standardized definitions that describe rehabilitative care resources across the continuum (including Assess and Restore).

DEVELOPMENT OF THE BACKGROUNDER DOCUMENT

This 'Backgrounder' document includes the following sections:

Section 1 - Information collected from national rehabilitative care providers from across Canada during interviews conducted by the Rehabilitative Care Secretariat from July to September 2013.

Section 2 - Information collected from Ontario rehabilitative care health service providers during a "Request for Information" process conducted by the Rehabilitative Care Alliance Secretariat from July to September 2013.

Section 3 - Findings of a literature review of relevant terminology related to the objectives and deliverables of the Definitions Task Group.

Section 1 – Information Collected from National Rehabilitative Care Providers

(Note: For the complete description of the interviews conducted with national rehabilitative care providers, please see Appendix A)

The names of potential national rehab contacts were received from Canadian Institute for Health Information (CIHI) (specifically, the CIHI Rehabilitation National Advisory Committee) and from internet searches, and existing national contacts held by the Alliance secretariat. Potential contacts were e-mailed and provided with information about the Ontario Rehabilitative Care Alliance, its priority initiatives and the issues/questions about which the Alliance was seeking information. Contacts were asked to respond to the Rehabilitative Care Alliance if they were interested in/able to participate in an interview with the Rehabilitative Care Alliance Secretariat. In total 9 interviews were conducted with rehab providers across seven provinces (SK, NB, BC, NFLD, NS, MB, AB) between July and September 2013.

In total, 3 questions/issues were discussed during the interviews. The question that was asked that is relevant to the Definitions Working Group was: "*Describe the flow from acute care to bedded inpatient rehab programs - especially for clients who have low functional tolerance and/or intensive medical needs. How do you determine eligibility for rehab? How do you define restorative potential?*"

[1] Provincial Rehabilitation and Complex Continuing Care Expert Panel: Phase 1 Report (2011)

Summary of Key Points

- While no other provinces report having a "Complex Continuing Care" level of care, most report having some level of "post-acute" care targeted towards patients with high/complex medical needs and/or low functional tolerance. Ontario does seem to have a more complicated post-acute sector by virtue of the number of named programs each with different intake/eligibility criteria and models/intensity of care.
- Like Ontario, most contacts report challenges in finding a post-acute rehabilitative care program to appropriately address the functional and/or medical needs of low tolerance, long duration-type clients. Also like Ontario, most contacts identify this as a barrier to timely discharge from acute/access to post-acute rehabilitative care and a contributor to acute length of stay.
- Ontario is not unique in being challenged to collect, report and compare data across the inpatient rehabilitative care continuum. Most provinces use multiple databases across the rehabilitative care continuum depending on the setting in which the rehabilitative care program is offered.
- Only one of the contacts (Nova Scotia) described using a standardized measure (Barthel Index) to determine eligibility for inpatient rehab.
- One contact (NFLD) described using 'restorative potential' as the determination for eligibility to inpatient rehab. Restorative potential was described as 1) having measurable goals, 2) a discharge plan, 3) demonstrated ability and/or expectation of ability to make functional gains. Another contact (AB) described using predicted ability to return home as basis for determining 'restorative potential'. This was determined by considering age and impairment severity, social support and pre-morbid function.
- The Alberta contacts describe maintenance of outpatient rehab resources and identified initiatives and investments in outpatient services as being a key emerging approach to facilitating flow through acute and post-acute/inpatient rehab programs. The BC contact also described a shift from a focus on inpatient to outpatient rehab with access to outpatient resources managed regionally through a central intake mechanism.

Summary of National Feedback

New Brunswick (New Brunswick Department of Health)

- Most inpatient rehab programs are within acute care facilities and patients must be "discharged" from acute and "re-admitted" to rehab even though they have only changed units within the same facility. Individual organizations may designate/utilize acute beds as rehab. The only ministry-designated rehab beds are at the single provincial tertiary centre.
- High functioning patients who can manage at home currently do not access inpatient rehab. These patients typically return home with support (outpatient, home care, travelling rehab teams).
- No CCC level of care. There are strategies in place to manage complex patients e.g. long term vents managed at home
- Patients' transportation needs are supported by the Social Development Department of the Ministry, based on finances and need.

British Columbia (Fraser Health Authority)

- British Columbia, as a province, is working to standardize what type of therapy is provided in inpatient rehab across all Health Authorities (HAs). This is being accomplished through regular meetings of Rehab Directors from each of the 5 Regional Health Authorities.
- Currently, the number of beds varies between HAs with differences in how they are used/models of care. As a result, there is limited ability to compare data between slow stream, high intensity or convalescent care (CC) as different databases are used in each setting/program.
- It is generally a struggle to place low tolerance, long duration-type clients as they are usually unable to tolerate the intensity of programming provided in inpatient rehab programs. There are attempts to support LTLD-type clients in high intensity rehab but this affects flow.
- There are also convalescent care programs in long term care for patients who are not yet "rehab ready". Convalescent care includes a functionally focused model of care (OT/PT, dining room, ADLs) and the RAI is used for selection and eligibility. Once the convalescent care team assess that the patient is "rehab ready", an application to rehab is submitted.
- In terms of eligibility for rehab, programs try to steer away from being too prescriptive/documenting eligibility criteria because they find that it eliminates people who might benefit. A central intake service uses clinical judgement in combination with the information that is collected/reported via Meditech (including rehab goals, discharge plans, recent progress etc.) to evaluate eligibility and the most appropriate program.
- There is a shift from inpatient to outpatient care with outpatient access managed regionally through a central intake (referral information submitted electronically via Meditech).

Nova Scotia (Nova Scotia Rehabilitation Centre)

- Nova Scotia Rehabilitation Centre is the only provincial tertiary centre and has a very limited ability to manage medical acuity/complexity (e.g. there is no in-wall gas, reduction to 6 staff at night over 3 floors). Therefore, patients stay in acute until they are completely medically stable.
- There is no level of care comparable to CCC in Nova Scotia – felt to be a gap in the system. In the absence of a CCC-type level of care it is challenging to manage complex patients outside of acute care.
- The Centre used to have a sub-acute floor (captured NRS data). The staffing ratio in sub acute was 1:12-14. Patients were moving too much between floors and LOS was too long. These beds had low occupancy rates. The unit inherited patients waiting for LTC and patients who had completed their tertiary rehab and were waiting transfer back to local facility. The sub-acute unit was closed because there was no flow.
- The Barthel Index is used in acute care to determine the need for post-acute rehabilitation
- Nova Scotia doesn't have the same community resources as Ontario. Also, distance to travel is so great people have to be admitted for short stays to manage issues that might otherwise be dealt with via ambulatory services.

Newfoundland (Dr. L.A. Miller Center, St. John)

- Two levels of rehab - low intensity rehab beds (provides the same level of rehab as regional hospital programs) and 42 high intensity beds (SCI, ABI, stroke)
- FIM is done on admission and discharge although the FIM is not required for admission.
- Patients who have medical complexities (e.g. O2 needs etc.) stay in acute care due to limited availability of resources to manage medical issues/complexities.
- Criteria for admission to low intensity program: Patient can tolerate PT/OT 1/2-1 hour combined therapies 3x/week (may get more). Criteria for admission to high intensity program: Patient can tolerate 1 hour/day combined SLP, OT, PT 5x/week. Eligibility determination completed through intake committee (all disciplines involved in making decision) by evaluating **restorative potential** (have measurable goals, d/c plan, can make gains).

Manitoba (Winnipeg Regional Health Authority)

- Instead of 'Complex Continuing Care', have 'Chronic Care' w higher nursing ratio than rehab. Chronic Care used to offer care to long-stay/permanent residents with complex medical needs that can't be managed in LTC. Rehab and Chronic Care used to be under a single "rehab program portfolio," however, units were not blended. This allowed for a single budget structure i.e. no reallocation/renaming/changing budget sources. However, this created issues with data (Rehab = NRS, Chronic Care = DAD, LTC = MDS) and Accreditation standards. Two years ago, a decision was made to place Chronic Care under LTC program portfolio.
- A 'Coordinated Entry System' approach to rehab, CC, LTC is overseen by a 'Waitlist Coordinator'. There is also a dedicated clinician at each acute care site to help to triage referrals to Geriatrician/Physiatrist (if this is required to determine eligibility for inpatient rehab) and ensure that referrals for post-acute care have been made to the appropriate level of care. Note: Some rehab programs require that consultation service (geriatrician, physiatrist, dedicated consultant) needs to complete assessment and approve the referral prior to acceptance.
- 'Coordinated Entry System' (CES) to manage flow from acute care and the community to post-acute beds across the HA. The CES includes a web-based database/tracking system to help track referrals, manage waitlists to all programs (rehab, CC, LTC, GATs etc.) and report waitlists. There is a daily bed conference call to discuss/report current status at each organization (ER holds, ALC, anticipated discharges etc.) and to ensure the needs of the community outreach teams are included/considered. NOTE: Outreach Teams (community and ER geriatric consults) in place to do early assessment and intervention (based on Ottawa-Carleton outreach team model).
- Organization of bedded rehab – Recently moved away from long term/short term rehab to instead structure rehab units around condition-specific programs (e.g. geriatric rehab, stroke rehab, ABI rehab etc).

Alberta

<u>Foothills Medical Centre</u>

- Never had CCC. Limited designated rehab beds other than those at limited standalone facilities. Rehab beds at acute facilities designated 'rehab' as needed at the organizational level.

- In order to avoid bottle necks in rehab (created by patients with low tolerance, longer lengths of stay and by those who ultimately require/wait for LTC) the hospital started to become focused on stricter admission criteria in the mid-90s. For example, it focused on admitting those who had potential for improvement enough to go home. Admission criteria became largely focused on discharge destination (i.e. eligible if expected to go home, not LTC).
- Those who needed rehab but likely still to require LTC were put into a newly developed transition care unit (slower pace, lower intensity for clients waiting for long term care). The transition level of care (for frail elderly and orthopedics) is viewed as "unavoidable" because there has to be a place for lower functioning clients who need to be moved out of acute (in order to meet QBP-type targets). Some transition units are located in LTC homes. "Transition units" (similar to the "Sub-acute Complex Medical" level of care as recommended in Ontario's Senior Strategy) are focused on patients going to LTC (i.e. can't be transferred to transition unit until LTC application has been initiated and accepted)
- Inpatient rehab beds are focused on patients with mild/moderate strokes while patients with severe strokes (less than FIM 40) are sent to LTC (out of a lack of capacity in rehab). Young patients with severe strokes can go to inpatient rehab. A special interdisciplinary team (Association for the Rehabilitation of the Brain Injured - ARBI) follows these patients with severe strokes in LTC to develop progressive functional/rehabilitative care treatment plans. Some patients are able to be discharged from LTC.
- 'Restorative potential' and eligibility for rehab is largely based on predicted ability to return home as determined by considering age and stroke severity. Also consider social support and premorbid function.

<u>Glenrose</u>

- There is no CCC/slow stream rehab – therefore, all slow stream type clients are sent to general inpatient rehab programs in Alberta increasing the average LOS. This is an issue in that Ontario hospitals are comparators. There are no funding considerations for slower stream rehab clients. Challenged to meet the needs of clients who need slower stream rehab from acute care if they are admitted to general/high intensity inpatient rehab programs.
- Have sub-acute units within freestanding centres - serve to move patients off of acute units until they are "rehab ready". Variable definitions and models of care within sub-acute programs.
- Focusing on timely access and increasing intensity of services in outpatient rehab in order to flow clients from acute and inpatient rehab. This additional capacity in outpatients was accomplished through funding re-allocation AND new investment.

Saskatchewan – Wascana Rehabilitation Centre

- The Centre follows the Evidence Based Stroke Rehab (EBSR) principles to determine eligibility for rehab e.g. if patients are out of bed for 4 hours a day, medically stable and can learn they are targeted to "active rehab" which should mean 3 hours of scheduled activities in a day.
- Other levels of care include:
    - Geriatric rehab - fewer hours of activity for frail clients
    - "Convalescent" beds - typically in a long term care facility but which are used to allow some healing time and planning for return to the community

  - "Transition" beds - designed for those with a less clear prognosis for return to home or supported living in the community.
  - "Alternate level of care" (ALC) beds – basic nursing care provided to those patients for whom it is believed that long term heavy institutional care is going to be required.
- Eligibility for inpatient rehab is determined by a central group
- "Fragile" people with joint replacement and multiple medical problems also are sent to the lower intensity "Geriatric", "Convalescent" or "Transition" beds. These fragile patients are the same group that Ontario has dealt with under the "Complex Continuing Care" rubric.
- The health regions other than Regina and Saskatoon generally have populations of fewer than 60,000 so the scale, specialization and methodology are less organized and less standardized.

Section 2 –Information Collected from Ontario Rehabilitative Care Health Service Providers

(Note: For the complete description of the information collected from Ontario rehabilitative care health service providers, please see Appendix B)

In order to develop an understanding of the current landscape in Ontario related to rehabilitative care, a "Request for Information" process was conducted by the Rehabilitative Care Alliance Secretariat from July to September 2013. This process was used to collect information from Ontario rehabilitative care health service providers regarding a number of issues and to develop an understanding of the needs of rehabilitative care system stakeholders in Ontario. The following is a summary of the information that was collected in response to the following question:

Please describe, and provide supporting references/documents, regarding any local work or initiatives that have been completed or are underway, that might help to inform the Definitions Initiative of the Rehabilitative Care Alliance. Specifically, what information/definitions would be helpful to support the work that you are doing in your LHIN i.e. What does you LHIN need from the Definitions Task Group?

Summary of Key Points

- There is a need for clarity regarding the fundamental components of rehabilitative care provided in rehabilitative care to Rehab Client Groups (RCGs) in inpatient, outpatient and community rehabilitative care settings.
- Clear and standardized definitions are required describing the elements of the care delivery models within the various levels of rehabilitative care, such as:
  - Minimal and ideal model of care and care components (staffing ratios, equipment and space requirements)
  - Admission criteria/eligibility
  - Readiness for discharge/discharge criteria
  - Level/intensity and volume of services
- Solutions need to consider the geography of Ontario and be able to have flexibility when looking at rural areas. Need to be guided by principles of equitable access and care close to home

- There is a need to differentiate between Geriatric rehab, Convalescent Care and Assess and Restore – these definitions are blurring and causing more confusion for front-line staff
- There is a need to define and standardize Assess and Restore as a program/philosophy
- Ontario requires a strategy to manage patient populations that are not completely ready for rehab but will need rehab for full recovery. These patients are too unwell or require too much care for home environment even with home care
- Provincial level planning and definitions will further inform local work and assist in planning for system capacity
- A knowledge translation plan and guide/tool box is required to support operationalization of the definitions as well as support to disseminate information and manage changes with the front line level
- Solutions must align with other initiatives such as RM&R, Seniors Strategy and the CCAC Expanded Role
- Require clarity on the role of the Rehabilitative Alliance in compliance and implementation of the definition standards within the 14 LHINs

Section 3 –Literature Review of Relevant Terminology Related to the Objectives and Deliverables of the Definitions Task Group

(Note: For the complete description of the literature review of relevant terminology related to the objectives and deliverables of the Definitions Task Group, please see Appendix C)

In an effort to collect relevant historical and contemporaneous information to inform the work of the Definitions Task Group, a search of literature related to rehabilitative care definitions was conducted between July and September 2013. The following documents were used to develop a list of definitions regarding levels of rehabilitative care in Ontario:

1. Admission to Long Term Care Homes Community Care Access Centres - Community Care Access Centres Client Services Policy Manual,(nd) Ministry of Health and Long Term Care. Retrieved on Sept, 11, 2013 from http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm_sec_11/11-10.html
2. An Integrated Program for Complex Care in the Hamilton Niagara Haldimand Brant Local Health Integration Network - Final Report from the Task Group on Coordinated Strategy for Complex Care to the Hamilton Niagara Haldimand Brant. Approved by HNHB Local Health Integration Network Board of Directors on June 29, 2010
3. Complex Continuing Care Co-payment 2010, Ontario Ministry of Health And Long Term Care Retrieved on Sept 24, 2013 from http://www.health.gov.on.ca/en/public/publications/chronic/chronic.aspx
4. HNHB LHIN Restorative Care Bed Review: Final Report and Recommendations, April 2013
5. Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)
6. Long-Term Care Homes Act, 2007
7. Managing the Seams : Making the Rehabilitation System Work for People - The Rehabilitation Reform Initiative, Prepared by: Provincial Rehabilitation Reference Group, March 2000 (Revised August 2000)
8. “Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System”, Ontario Hospital Association, May 2006.
9. Outpatient Rehabilitation in the GTA: Understanding the Current State (GTA Rehab Network, June 2011)

10. Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies, Health Services Restructuring Commission, 1997 Retrieved on Sept. 24, 2013 from http://www.ontla.on.ca/library/repository/mon/1000/10268030.pdf
11. Rehab Definitions Initiative, Final Report , March 2010, GTA Rehab Network
12. Rehabilitation and Complex Continuing Care Expert Panel, Phase I Report, June 2011
13. Rehabilitative Care Conceptual Framework, Definitions Working Group for the Rehabilitation and Complex Continuing Care Expert Panel, November 2011
14. Transitional Care Program Framework - Health System Performance and Accountability Division, MOHLTC (August 2010)

Summary of Key Points

- Many sources of definitions of rehabilitative care 'levels of care' exist. The variability in wording and nuances in descriptive details often create confusion and the potential for differences in interpretation.
- Rehabilitative care 'levels of care' are described in the literature according to:
    - Length of time service is needed/length of stay
    - Intensity of services
    - Degree of specialization of services
    - Locality of services
    - Location/Siting
    - Populations/conditions that are served
- Various programs have been developed at regional, local and organizational levels that include various combinations of the above descriptors (e.g. Convalescent/Supportive Care, Assess and Restore, Reactivation, Functional Enhancement, Restorative Care, Transitional Care etc.)
- The definitions of Complex Continuing Care contain conflicting information about the degree of medical stability that is required to access and/or manage within the CCC level of care. Additionally, the literature contains information about several sub-levels of CCC that have been developed at regional, local and organizational levels. These include various combinations of the above descriptors (Medically Complex Stream, Restorative Care) which likely create confusion for system stakeholders.

Concluding Comments

Variability in definitions describing rehabilitative care levels of care, programs and resources is contributing to critical issues with access to and flow through the rehabilitative care system. Data quality and reporting is also compromised by inconsistent use of terms. Standardization is required at all levels (patient/caregiver, health service provider, organizational, LHIN and provincial) to support optimization of the rehabilitative care system's contribution to health care system goals.

The information contained in this document will be used by the Definitions Working Group of the Rehabilitative Care Alliance to support its efforts to develop standardized definitions describing rehabilitative care resources across the continuum. These definitions will be developed in consideration of local, provincial and national trends and directions as well as existing and emerging definitions related to rehabilitative care resources and levels of care.

Appendix A –Detailed description of the responses attained during interviews conducted with national rehabilitative care providers to the following question: ***"Describe the flow from acute care to bedded inpatient rehab programs - especially for clients who have low functional tolerance and/or intensive medical needs? How do you determine eligibility for rehab? How do you define restorative potential?***

	Name	Position/Title	Province	Response/Discussion
1	Bonnie Boudreau	Clinical Data Analyst - Accountability & Health Information Management, New Brunswick Dept. of Health	NB	• "Level of care abstracting" is completed so that when a patient finishes the acute care portion of their treatment, they are discharged and readmitted to the rehab part of their stay although they may have only changed nursing units and have not actually been discharged from the hospital. Currently, one of the rehab units in a regional facility and the tertiary rehab facility use NRS. The other facilities currently use the DAD post-acute and place the patient either in the chronic or rehab level of care. Provincially, there is discussion of moving all non-acute patients to the CCRS and only the tertiary rehab facility would use the NRS system
2	Jennifer Elliott	Healthcare Consultant Extra Mural Program and Rehabilitation Services, New Brunswick Dept. of Health	NB	• High functioning patients who can manage at home currently do not access inpatient rehab. These patients are supported to return home with support (outpatient, home care). Some patients are admitted to inpatient rehab for tests – this is recognized as an inappropriate use of resources and alternate solutions are being developed to address this issue. NB also looking to ensure that patients who require admission to inpatient rehab to prevent secondary complications/readmission are able to do so. • No defined rehab beds except provincial tertiary rehab beds • The rehab continuum includes inpatient, outpatient, home care and travelling clinics • No CCC level of care. There are strategies in place to manage complex patients e.g. long term vents managed at home • Patients with transportation needs are supported by the Social Development Department of the Ministry, based on financial need • Data Collection through MIS is completed in both the inpatient and outpatient settings e.g. %/Number of patients seen by OT/PT in inpatient and outpatient, service recipient workload • Tertiary centre reports NRS data in inpatient only • Developing a framework for tertiary centre to ensure that data that is being collected is valid, benchmarked, actionable and will support monitoring of performance and outcomes. • There are set standards for rehab total productivity i.e. provincial targets and benchmarks including patient care time + indirect time/total hours. This Ministry looks at this data as a

	Name	Position/Title	Province	Response/Discussion
				combined total of inpatient and outpatient (rather than broken out by setting) • Ministry/Administrators have looked at (i.e. shadowed) "high performers" (i.e. those with high total productivity) to identify what those providers do. For example, do they deliver high quality outcomes (this is challenging to do in the absence of a clear definition of 'high quality care")? This process is informing efforts to identify indicators of high quality care. • Programs do their own patient experience surveys. The New Brunswick Health Council has also done a patient experience survey of home care (see website for results) to largely measure satisfaction with care coordination. This survey was developed based on other national, validated surveys. The survey will be repeated every four years. Data has pushed development of new strategic plan for home care and allows for evaluation of areas that are being served well/not well.

3	Joy Parsons	Director of Fraser Health Rehab Program, Fraser Health	BC	• Fraser Health is one of 5 Health Authorities (HA), includes 13 hospitals
				• British Columbia , as a province, is working to standardize what type of therapy is provided in inpatient rehab across all Health Authorities
				• All 5 Health Authorities have a Rehab Director who meet regularly.
				• There are 2 types of rehab :
				  ○ general rehab – typically older patients who receive daily, but less intensive rehab, LOS 15-30 days, no FIM, no functional outcome database
				  ○ high intensity rehab (shorter LOS, using FIM, piloting alpha FIM).
				• Fraser HA has deemed rehab as a regional program including inpatient and outpatient. Other HAs have arranged rehab around conditions rather than level of service. Fraser Health is moving towards more population focused (stroke, MSK etc.) care
				• Inpatient units largely focused on high intensity, short duration (stroke, MSK, general complex).
				• The HA struggles to place low tolerance, long duration-type clients. Try to support LTLD in high intensity rehab but this affects flow.
				• Occasionally transfer out to Alberta for specialized programs (ABI).
				• Eligibility for rehab - steer away from being too prescriptive/ documenting eligibility criteria because find it eliminates people who might benefit. Use rehab goals (REHAB) acronym, discharge plans, recent progress etc.
				• Eligibility info is collected via screeners and inputted into Meditech. Central intake service looks at goals then matches goals with appropriate services and places them via a regional intake model.

	Name	Position/Title	Province	Response/Discussion
				• LTC also has convalescent programs – for patients not yet "rehab ready". Includes a functionally focused model of care (OT/PT, dining room, ADLs). Use RAI for selection and eligibility. Once convalescent care team assesses that patient is "rehab ready", re-apply to rehab. • # of beds varies between HAs and there are differences in how they are used/models of care . Can't compare data between slow stream, high intensity or CC. • There is a shift from inpatient to outpatient care with outpatient access managed regionally through a central intake (referral information submitted electronically via Meditech).
4	Carmel Lester	Manager of Intake Coordination and Data Management, Dr. L.A. Miller Center, Eastern Health, NL	NFLD	• Dr. L.A. Miller Center has a total of 62 beds: 20 low intensity rehab beds (provides the same level of rehab as regional hospital programs) and 42 high intensity beds (SCI, ABI, stroke) within a stand-alone facility. • If a patient is not from St. John's and needs low intensity rehab, will go back to regional hospital. • High intensity rehab program is a provincially mandated service i.e. is obligated to take all clients from province. • Common, 5-page referral form for both high and low intensity programs • FIM is done on admission and discharge. FIM not required for admission. • Patients who have medical complexities (e.g. O2 needs etc.) stay in acute. 24 hour medical coverage not available on site. Also, RT available on call as opposed to on site • Criteria for admission to low intensity program = patient can tolerate PT/OT 1/2-1 hour combined therapies 3x/week (may get more). Population within low intensity beds is usually elderly but can also be a deconditioned patient. • Criteria for admission to low intensity program = patient can tolerate 1 hour/day combined SLP, OT, PT 5x/week • Eligibility determination completed through intake committee (all disciplines involved in making decision) by evaluating restorative potential (have measurable goals, d/c plan, can make gains) • As part of a plan to open 400+ LTC beds, are considering opening CCC-type beds. • No convalescent care.

	Name	Position/Title	Province	Response/Discussion
5	Randi Monroe	Director, Rehabilitation and Supportive Care, Nova Scotia Rehabilitation Centre, Halifax	NS	• Nova Scotia Rehabilitation Centre is part of Capital Health HA which includes 50% of the population of NS. The Nova Scotia Rehabilitation Centre in Halifax has 66 inpatient rehab beds (recently added 6 beds) and is the only provincial tertiary centre. There is limited ability to manage any medical acuity (e.g. there is no in-wall gas, reduction to 6 staff at night who cover 3 floors). Therefore, patients stay in acute until they are completely medically stable. • Post-neurosurgical rehab is very limited because can't handle/provide level of complex/speciality care. Nova Scotia Rehabilitation Centre is considering a CCC/ABI unit. • There is no level of care comparable to CCC in Nova Scotia – felt to be a gap in the system. In the absence of a CCC-type level of care it is challenging to manage complex patients. • All 9 district hospitals have a District Stroke Coordinator. • Once patients progress to a certain level within inpatient rehab, they transition to local restorative units. • SW navigates for complex patients. • Currently, ability to report ALC is limited. Looking at UMS/Medworx to support tracking of ALC, ALC LOS. • Collect NRS in inpatient rehab beds. • There is a 1:6-7 staffing ratio in inpatient rehab • Used to have sub-acute floor (captured NRS data). Staffing ratio in sub acute was 1:12-14. Patients were moving too much between floors and LOS was too long. These beds had low occupancy rates. Inherited patients waiting for LTC and patients who had completed their tertiary rehab and were waiting transfer back to local facility. The sub-acute unit was closed it because there was no flow. • Currently there are 3 units over 3 floors at Nova Scotia Rehabilitation Centre – 1)cognitive behaviour/ABI, 2) neuro/SCI, 3) MSK (Trauma, amp) • 6 years ago, a stroke strategy was developed whereby 6 restorative sub-acute centres were developed for stroke patients • Halifax is looking to lead the development of a provincial rehab strategy. • Admission criteria - don't use FIM to determine eligibility. Barthel Index is used in acute to determine need for post-acute rehabilitation • Nova Scotia Rehabilitation Centre has a 'Rehab Assessor' who is the 'gate keeper' for admissions to the facility. This person manages and prioritizes the waitlist. 40-50 people waiting for rehab in

	Name	Position/Title	Province	Response/Discussion
				province - some are from the community. For example, of the admissions to the MS program, 1/3 are from acute, 2/3 are from a local hospital or community. • Nova Scotia doesn't have the same community resources as Ontario. Also, distance to travel is so great people have to be admitted for short stays to manage issues that might otherwise be dealt with via ambulatory services.
6	Marlene Graceffo and Eva Carpisa	WRHA Rehab & Geriatrics Regional Director, Deer Lodge Centre, Winnipeg, Manitoba Regional Manager Physiotherapy Outpatient and Educational Services Manager of PAR Health Services RR136-800 Sherbrook Street Winnipeg, MB R3A 1M4	MB	• Rehab at 5 sites, 7 hospitals, and 9 facilities in all of Winnipeg region. • Instead of 'Complex Continuing Care', have 'Chronic Care' w higher nursing ratio than rehab. Chronic Care offers care to long-stay/permanent residents with complex medical needs that can't be managed in LTC). Rehab and Chronic Care used to be under a single "rehab program portfolio," however, units were not blended. This allowed for a single budget structure i.e. no reallocation/renaming/changing budget sources. However, this created issues with data, and Accreditation standards. Rehab = NRS, Chronic Care = DAD, LTC = MDS. • 2 years ago decision was made to place Chronic Care under LTC program portfolio. • 'Coordinated Entry System' approach to rehab, CC, LTC is overseen by a Waitlist Coordinator. There is also a dedicated clinician at each acute site to help to triage referrals to Geriatrician/Physiatrist (if this is required to determine eligibility for inpatient rehab) and ensure that referrals for post-acute care have been made to appropriate level of care. Note: Some rehab programs require that patients be accepted/approved by a consulting physician prior to acceptance. • Longer waiting list for CC than rehab (due to low flow). • Recently developed 1 pager to clarify eligibility criteria for levels of care. Consultation service (geriatrician, physiatrist, dedicated consultant) needs to complete assessment and approve the referral. • Geriatric Assessment Outreach Teams (community and ER geriatric consults) to do early assessment and intervention (based on Ottawa-Carleton outreach team model). Have developed a web-based database/tracking system to help track referrals, manage waitlists to all programs (rehab, CC, LTC, GATs etc.). Bed conference call daily to discuss/report current status at each organization (ER holds, ALC, anticipated discharges etc.) to help 'Coordinated Entry System' to manage flow. Includes outreach teams to communicate needs from community. • Organization of bedded rehab - moved away from long term/short term rehab. Structured rehab units around geriatric rehab, stroke rehab and ABI rehab (9), amputee rehab (9), SCI (13), neuro-

	Name	Position/Title	Province	Response/Discussion
				musculoskeletal (MS, GBS etc.) (7). Looking to restructure bed base due to lack of geriatricians, long waitlist for other speciality rehab programs. Also looking to develop sub-acute/complex medical level of care. • Primary care has little role in accessing rehab bed from community.
7	Luchie Swinton (Note: conversation largely from stroke perspective)	Rehabilitation Practice Lead Stroke Action Plan Project Cardiovascular Health & Stroke SCN, Foothills Medical Centre	AB	• Have never had CCC • Limited designated rehab beds at all (other than those at limited standalone facilities - Glen Rose, Brain Injury rehab unit). Rehab beds at acute facilities formally considered acute care beds. Designated 'rehab' as needed at the organizational level. • Because patients with low tolerance are sent to inpatient rehab, LOS is increased and a bottle neck is created in rehab (as some patient wait for LTC). • In the mid-90s started to become focused on stricter admission criteria (i.e. those who had potential for improvement, could make gains enough to go home, largely focused on discharge destination i.e. eligible if expected to go home, not LTC). • Those who needed rehab but likely still to require LTC put into newly developed transition care unit (slower pace, lower intensity for clients waiting for long term care) • Inpatient rehab beds focused on mild/moderate strokes while severe strokes (less than FIM 40) sent to LTC (out of a lack of capacity in rehab). Young severe strokes can go to inpatient rehab. A special ID team (ARBI) follows these severe strokes in LTC to develop progressive functional/rehabilitative care treatment plan. Some are able to be discharged from LTC. • 'Restorative potential' and eligibility for rehab largely based on predicted ability to return home as determined by considering age and stroke severity. Also consider social support and premorbid function. • In Calgary, other than orthopedics no designated rehab for non-neuro units. Also, have a geriatric assessment and rehabilitation unit at 1 acute site in Calgary. Edmonton (Glen Rose) (stand-alone) has transition, GARU, neuro, ortho. • Transition level of care (for frail elderly and orthopedics) "unavoidable" because have to have a place for lower functioning clients who need to be moved out of acute (in order to meet QBP-type targets). Some transition units located in LTC facilities. "Transition units" largely similar to recommended "Sub-acute Complex Medical" except transition unit more focused on patients going

	Name	Position/Title	Province	Response/Discussion
				to LTC (i.e. can't be transferred to transition unit until LTC application has been initiated and accepted)
8	Lisa Froese	Site Director, Glenrose Rehab	AB	• There is no CCC/slow stream rehab – therefore, all slow stream type clients are sent to general inpatient rehab programs in Alberta increasing the average LOS. This is an issue in that Ontario hospitals are comparators. • There are no funding considerations for slower stream rehab clients. • Challenged to meet the needs of clients who need slower stream rehab. Have a fluctuating number of slow stream rehab beds currently 4 beds for this. • Have sub-acute units/early supported discharge within freestanding centres - serve to stream patients off of acute units until they are "rehab ready". Variable definitions and models of care within sub-acute programs. • Restorative Care initiative - looking at transitions of care. • Destination Home - similar to Home First/Wait at Home. • "Move Easy" - similar to Ontario's "Move on" (using volunteers to mobilize clients in acute and rehab). • Focusing on timely access and increasing intensity of services in outpatient rehab in order to flow clients from acute and inpatient rehab. This additional capacity in outpatients was accomplished through funding re-allocation AND investment.

	Name	Position/Title	Province	Response/Discussion
9	Milo Fink	Physiatrist & Section Head, Physical Medicine, Wascana Rehabilitation Centre, SK	SK	•For our most common rehab diagnosis of stroke and when the patients are seen in Regina or Saskatoon, we follow the generally accepted guidelines for screening for tolerance for available interventions and potential benefit from those rehab interventions. •The Evidence Based Stroke Rehab (EBSR) principles originally developed by Bob Teasell and his group at UWO is the gold standard to which we aspire. e.g. if patients are out of bed for 4 hours a day, medically stable and can learn they are targeted to "active rehab" which should mean 3 hours of scheduled activities in a day •The more fragile and old might go to "Geriatric rehab" where there are fewer hours of activity. •There are also "Convalescent" beds which are typically in a long term care facility but which are used to allow some healing time and planning for return to the community. •There are also "Transition" beds which are designed for those with a less clear prognosis for return to home or supported living in the community. •Finally there are the "alternate level of care" (ALC) beds where the gate keepers believe that long term heavy institutional care is going to occur regardless of what we do. Those patients receive basic nursing care and there is a designated unit in one of the hospitals in Regina. •Gatekeeping for units other than active rehab is done in Regina by a committee of people mostly with a social work background. I think there is a problem with that gatekeeping because the group making the decisions "do not know what they do not know....." •Fragile people with joint replacement and multiple medical problems also are sent to the lower intensity "Geriatric", "Convalescent" or "Transition" beds, none of which are in hospitals in Regina. In Saskatoon the Geriatric unit is in Saskatoon City Hospital where it functions in close proximity to the active rehab unit. I believe that as part of ongoing analysis, the relationships and flow in Saskatoon between geriatrics and active rehab will become more synchronized. These fragile people, I believe are the same group that Ontario has dealt with under the "Complex Continuing Care" rubric. •The health regions other than Regina and Saskatoon regions generally have a population of fewer than 60,000 so the scale, specialization and methodology is less organized and less standardized.

Appendix B - Description of the information collected from Ontario rehabilitative care health service providers. Responses have been included where feedback was available/provided.

Question #1 - Please describe, and provide supporting references/documents, regarding any local work or initiatives that have been completed or are underway, that might help to inform each of the four priorities of the Rehabilitative Care Alliance. NOTE: Please refer to the work plan for more detail related to each of these initiatives.	
Priority #1 - Definitions Initiative **What information/definitions would be helpful to support the work that you are doing in your LHIN i.e. What does you LHIN need from the Definitions Task Group?**	
Central	LHIN-wide rehab inventory conducted as part of the ALC Rehab LHIN-wide initiative Report standardization as per the MIS/MOH guidelines Standardization cross LHIN for all LHIN-wide care maps developed
Champlain	1) Clinical guidelines for rehabilitation client groups – we have clinical guidelines to support the implementation of QBPs for hip fractures, stroke and TJR more work needs to be done in all areas of rehab. 2) Along with the above, would suggest standard definitions of service and what this encompasses. e.g. What are the minimum and ideal care components, staffing requirements, equipment and space requirements to provide SCI rehab, stroke rehab, etc…, Are there volumes that are recommended to maintain competencies and to ensure efficiencies of scale? If a Best Practice Recommendation recommends 3 hours of rehab a day what does this entail? This point should include outpatient and community services – what are the requirements to maintain gains, how do we set these programs up, what are the care components required, where is the best siting of these services? We however always need to consider the geography of Ontario and be able to have flexibility when looking at rural areas. Access to Rehab services close to home is still a principle we need to be guided by. 3) Differentiate between Geri rehab, convalescent care and assess and restore – these definitions are blurring and causing more confusion for front-line staff 4) What is assess and restore?
Central West	Other than the deliverables specified there is a patient population that also needs transitional care. I suspect this is out of scope but often there is a patient grouping not completely ready for rehab but will need rehab for full recovery. These patients are too unwell or require too much care for home environment even with home care.

ESC	In ESC we have completed a review of inpatient rehabilitation admission and discharge criteria and approved LHIN-wide guidelines for inpatient rehabilitation (attached). The purpose of these is related to our Rehabilitation System Strategic Plan Goal # 2: appropriate utilization of inpatient rehabilitation beds. Next steps include transition of this working group to undertake study of inpatient beds utilization, occupancy and capacity planning, including predictive modeling for system capacity for the next 5-10 years (priority patient populations include patients with stroke, hip fracture and frail elderly).We have one hospital in the LHIN with "slow stream rehab" beds although these are within CCC and do not report data in NRS. We look forward to this provincial level planning and definitions to further inform our work – and assist in planning for system capacity; whether or not we need to create "slow stream" rehabilitative care units, and where these should be located (discussion at LHIN level about non-hospital bedded alternative settings).In addition, Dr. Nathania Liem has been working for some time on a concept and service model entitled "Beyond Disability", aimed at patient populations in "Group 5" i.e. patients with long term conditions or life-long disabilities who require periodic interventions with knowledgeable providers.
NE	• Streams of rehab need definition including those in CCC beds • Admission criteria/eligibility – including A&R vs. CCC • Readiness for discharge, discharge criteria. Consistent application of ALC definition in rehab • Define level of service each would be expected to provide and minimal resources required. • This issue needs to be linked with RM&R ASAP.
NSM	It would be helpful to: • Define the full continuum of rehabilitative care. • Clearly define what the different descriptions within rehabilitation are (convalescent care, slow stream rehab …) so that we can understand where people should be on their journey (e.g. start and end of goal directed care). • Define triage guidelines similar to what is happening in most organizations with acute stroke patients having an AlphaFIM® completed and that score being used to guide appropriate discharge destination. Extending this to other populations will help to triage to the right rehab destination. • Have a knowledge translation plan and guide / tool box on how to operationalize definitions as well as support to disseminate information and manage changes with the front line level. Local work that may be helpful attached to RFI

NW	The NW LHIN would like to see the definitions of Complex Continuing Care, Convalescent Care, Assess and Restore, Medically Complex, and Frail Seniors. In addition to the definitions, the elements of the care delivery model should be addressed. This would encompass the treatments/care provided, as well as staffing/care professional ratios, clinical pathways for referral to such services, that align with other initiatives such as RM&R, Seniors Strategy and the CCAC Expanded role.
SELHIN	The triage tool: Medical Stability, Rehab Readiness and Candidacy through Rehab definitions and with that the acute care algorithms. The implementation of definition standards and self-assessment tools applied to all rehabilitative care programs in Ontario will support common definitions for providers, consumers, policy makers and funders. Standard definition will aid the LHIN in understanding the needs of the population, available current resources, lack of resources and assist in capacity planning. Clarity on the role of the Rehabilitative Alliance in compliance and implementation of the definition standards within the 14 LHINS? Develop a Provincial Rehab finder for programs/services based on the definitions
SWLHIN	The definitions that would support LHIN 2 are: 1. Link of CCC populations in a continuum within rehabilitative care 2. Clarity of population served in complex care provincially 3. Restorative care population definition 4. Ambulatory populations definitions 5. Interdisciplinary team composition recommended for comprehensive rehabilitative care 6. There is a need to define what post-operative rehabilitative care is required in acute care hospitals versus a rehabilitative program in an acute hospital or standalone organization.
TC	GTA Rehab Network has done a lot of work on definitions in describing a definitions framework and developing population specific definitions frameworks and self-assessment tools. See: http://www.gtarehabnetwork.ca/definition-frameworks A report was completed for TC LHIN related to definitions in March 2010. See http://www.gtarehabnetwork.ca/uploads/File/reports/report-rehab-definitions-intiative.pdf

WW	We are aligning our inpatient rehabilitative care beds within Dr. Sinha's Assess and Restore level of care (sub acute complex medical, Convalescent Care, Rehab). Would be helpful to have Alliance refine Dr. Sana's model to ensure rehabilitative care contributions are maximized. The Frail Elderly/Medically Complex Stream Steering Committee in Waterloo Wellington has developed a definition of frailty to guide their work in implementing a Comprehensive Geriatric Assessment (CGA). It would be helpful to see a definition from the RCA to compare. Also, we are looking at capacity planning at the rehab system as a whole (including restorative care, complex continuing care, convalescent care, etc.), and some definitions for these care settings and what level of therapy is to be provided in these settings would be helpful for system planning of these resources.

Appendix C - Description of the literature review of relevant terminology related to the objectives and deliverables of the Definitions Task Group

Source	Definition	Description
General Defintions		
Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies, Health Services Restructuring Commission, 1997 Retrieved on Sept. 24, 2013 from http://www.ontla.on.ca/library/repository/mon/1000/10268030.pdf	Rehabilitation	The provision of often time-limited, goal-oriented therapeutic services geared towards the restoration (optimization) of health, physical or other ability.
Rehabilitation and Complex Continuing Care Expert Panel – Definitions Working Group, 2011	Rehabilitative Care	A broad range of interventions that result in the improved physical, mental and social wellbeing of those suffering from injury, illness or chronic disease"
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Rehabilitation Goals	The functional objectives set by the client in partnership with the rehabilitation team. These are determined shortly after admission to the rehabilitation facility and generally form the basis for activities that will be included in the rehabilitation program.
Transitional Care Program Framework - Health System Performance and Accountability Division MOHLTC (August 2010)	Rehabilitation (hospital)	A nursing care unit where the beds are designated for the provision of rehabilitation services for inpatients that require physiological and psychosocial support related to medical and surgical conditions.
Managing the Seams: Making the Rehabilitation System Work for People - The Rehabilitation Reform Initiative Prepared by: Provincial Rehabilitation Reference Group, March 2000 (Revised August 2000)	Inpatient Rehabilitation - Facility-Based	Services that are provided within a facility (e.g. rehabilitation hospital; community hospital with rehabilitation beds; community hospital without rehabilitation beds; CTCs).

Source	Definition	Description
Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies, Health Services Restructuring Commission, 1997 Retrieved on Sept. 24, 2013 from http://www.ontla.on.ca/library/repository/mon/1000/10268030.pdf	Rehabilitation - Regional	Highly specialized programs targeted to clients with complex rehabilitation needs. Examples include acquired brain injury, spinal cord injury, amputee, and trauma, specialized respiratory and complex pediatric care. Regional programs require specialized expertise, critical mass and have sufficiently low volume that provision on a local basis is neither feasible nor cost effective. Siting: These programs should be provided in designated regional facilities to ensure critical mass and availability of specialized expertise.
Note: "Regional" replaced by "specialized" as per memorandum from John King, ADM to CEOs of Public Hospitals on June 6, 2002		
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Rehabilitation Facility - General	A facility that provides inpatient rehabilitation services in designated units, programs or beds within a general hospital that has multiple levels of care (i.e. rehabilitation, acute care, and chronic care, emergency). Rehabilitation clients receive multi-dimensional (physical, cognitive, psycho-social) diagnostic, assessment, treatment and service planning interventions.
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Rehabilitation Facility – Speciality	A facility that provides comprehensive inpatient rehabilitation services or specialized rehabilitation programs. This is often a freestanding hospital, but can be a specialized unit within a larger acute or chronic-care facility. In addition to interventions provided in a General Rehabilitation Facility, clients in a Specialty Facility also have access to more comprehensive services such as surgical specialists, orthotics, prosthetics, etc.
Definitions by Length of Stay/Intensity of Services		
Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies, Health Services Restructuring Commission, 1997. Retrieved on Sept. 24, 2013 from http://www.ontla.on.ca/library/repository/mon/1000/10268030.pdf	Short-term Rehabilitation (local)	Clients require fewer than ten days inpatient length of stay and are targeted to patients for prevention, or after an acute care episode, who do not require specialized expertise. Examples include musculoskeletal, stroke and other neurological conditions, and short-term geriatric rehabilitation. Siting: Short-term inpatient rehabilitation will be provided in acute care facilities to reduce the number of patient transfers, increase early intervention and provide a continuum of outpatient and in-home rehabilitation to strengthen the focus on community re-integration.

Source	Definition	Description
Note: "Local" not adopted by the Ontario Ministry of Health and Long-Term Care as per memorandum from John King, ADM to CEOs of Public Hospitals on June 6, 2002		
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Short Stay	One of the available options for coding Admission Class in the NRS. Refers to an inpatient rehabilitation stay lasting between 4 and 10 days. The client is admitted for abrief intervention (e.g. prosthetic adjustment), OR the rehabilitation stay lasts only between 4 and 10 days because of medical complications OR the client was discharged against medical advice
Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies, Health Services Restructuring Commission, 1997 Retrieved on Sept. 24, 2013 from http://www.ontla.on.ca/library/repository/mon/1000/10268030.pdf	Short Term Rehabilitation	Suitable primarily for those patients who have suffered an acute care incident without the complications of multiple diagnoses, advancing age, or other impairments but also includes those who have rehabilitation needs of a preventive nature. These patients require relatively short-term intensive rehabilitation before returning to their home and work environments.
HNHB LHIN Restorative Care Bed Review: Final Report and Recommendations April 2013	Slow Stream Rehabilitation Program	Patients, who are presently waiting in acute beds would be admitted and participate in a comprehensive slow stream rehabilitation program in order to enhance their functional and cognitive ability such that they may be eligible to be discharged home or to a retirement home with enhanced services provided through the CCAC Community Slow Paced Rehabilitation Program. (Source: Slow Stream Rehab Demonstration Projects May 2008) Target LOS = 45 days
Rehab Definitions Initiative Final Report March 2010, GTA Rehab Network	Low Tolerance Long Duration Rehabilitation Program (LTLD/slow stream)	Suitable for individuals in need of an interprofessional rehab approach to address specific rehab goals who also have chronic/complex conditions requiring 24-hour hospital care and who are expected to benefit from a slower-paced rehab program for a longer duration than is offered in dedicated or mixed rehab programs. LTLD rehab is most commonly delivered in a complex continuing care bed but may also be provided in a designated rehab bed. LTLD rehab programs may be located in acute care, rehab or complex continuing care hospitals.
Definitions by Degree of Specialization		
Managing the Seams: Making the Rehabilitation System Work for People	Specialization of	The degree to which rehabilitation services require the application of specialized professional and technological knowledge and expertise. Rehabilitation services vary in their degree of

Source	Definition	Description
- The Rehabilitation Reform Initiative Prepared by: Provincial Rehabilitation Reference Group, March 2000 (Revised August 2000)	Services	specialization. Some draw on more generalized expertise and can be provided at the local level, while others require more specialized expertise provided in a specialized environment (i.e. Regional Rehabilitation Hospitals). Despite an absence of hard data, it is suggested by many that aggregation of specialized services at the regional level is the most cost-effective way of delivering such services.
Rehab Definitions Initiative Final Report March 2010, GTA Rehab Network	Specialization - Mixed Rehab Unit	Formerly referred to as a General inpatient rehab unit, this type of unit is located in acute care and rehab hospitals, provides intensive rehabilitation and serves a variety of patient population groups. The mixed rehab unit is suitable for individuals who require 24-hour hospital care and are in need of an inter-professional rehab program using a coordinated approach.
Managing the Seams: Making the Rehabilitation System Work for People - The Rehabilitation Reform Initiative Prepared by: Provincial Rehabilitation Reference Group, March 2000 (Revised August 2000)	Specialization - General to Moderately Specialized	These services are delivered at the local level to clients with varying rehabilitation needs who do not require the specialized services offered at a regional rehabilitation facility.
Managing the Seams: Making the Rehabilitation System Work for People - The Rehabilitation Reform Initiative Prepared by: Provincial Rehabilitation Reference Group, March 2000 (Revised August 2000)	Specialization - Highly Specialized	These services are highly specialized and deliver services to clients with complex rehabilitation needs through regional rehabilitation facilities. Examples of such aggregated facilities include those serving people with acquired brain injury, burns, spinal cord injury, complex amputation, catastrophic trauma, and specialized respiratory and complex pediatric care needs. Regional programs create the necessary critical mass of clients and provide the clinical expertise and cohesion in order to provide the most effective service possible.
Definitions by Level, Program, Location of Care		

Source	Definition	Description
HNHB LHIN Restorative Care Bed Review: Final Report and Recommendations April 2013	Assess and Restore	The Assess Restore program will: • Provide an area where patients that have completed the acute phase of their hospital care can be assessed for longer term care needs in the community or a residential setting.• Provide an area where patients discharged from acute care receive the appropriate level of care to prepare them (recover strength, endurance and functioning) for discharge to the community or another appropriate residential setting. (Source: HNHB LHIN Assess Restore Program Model April 20 2009) Target LOS = 45 days
HNHB LHIN Restorative Care Bed Review: Final Report and Recommendations, April 2013	Assess, Restore & Reactivation	The Assess Restore Reactivation program will:• Provide an area where patients that have completed the acute phase of their hospital care can be assessed for longer term care needs in the community or a residential setting.• Provide an area where patients discharged from acute care receive the appropriate level of care to prepare them (recover strength, endurance and functioning) for discharge to the community or another appropriate residential setting. (Source: HNHB LHIN Assess Restore Reactivation Program Model June 14 2011). Max LOS = 90 days
"Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System", May 2006	Complex Continuing Care	"Complex continuing care is a specialized program of care providing programs for medically complex conditions whose condition requires a hospital stay, regular on-site physician care and assessment, and active care management by specialized staff."
Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies, Health Services Restructuring Commission, 1997 Retrieved on Sept. 24, 2013 from http://www.ontla.on.ca/library/repository/mon/1000/10268030.pdf	Complex Continuing Care	"..hospital based care required by persons whose condition is medically unstable (i.e. fluctuates through periods of exacerbation) and/or require skilled, technology based continuing care or intermittent care. Patients who have been classified as "clinically complex" (based on MDS RUGS III methodology) have one or more of the following conditions or care requirements and are likely most appropriately cared for in a chronic hospital or units; internal bleeding; parenteral/IV feeding; stage 4 ulcers; chemotherapy; acute medical conditions; suctioning; transfusions; lung aspirations; tube feeding; burns; dialysis; radiation; tracheostomy care; ventilator; or resident meeting the criteria for the Extensive Services or Special care categories. This care will be provided by chronic care hospitals and units…"

Source	Definition	Description
Complex Continuing Care Co-payment 2010, Ontario Ministry of Health And Long Term Care Retrieved on Sept 24, 2013 from http://www.health.gov.on.ca/en/public/publications/chronic/chronic.aspx	Complex Continuing Care	In Ontario, the term "complex continuing care" (CCC) is used interchangeably with "chronic care". Complex continuing care provides continuing, medically complex and specialized services to both young and old, sometimes over extended periods of time. CCC is provided in hospitals for people who have long-term illnesses or disabilities typically requiring skilled, technology-based care not available at home or in long-term care facilities. CCC provides patients with room, board and other necessities in addition to medical care.
An Integrated Program for Complex Care in the Hamilton Niagara Haldimand Brant Local Health Integration Network Final Report from the Task Group on Coordinated Strategy for Complex Care to the Hamilton Niagara Haldimand Brant Local Health Integration Network Board of Directors Approved June 29, 2010	Complex Care	Complex care is a specialized, time-limited program providing patients with complex medical conditions who require a hospital stay with ongoing onsite assessment and active care by an interprofessional team with a goal to enhance the health and quality of life. The CC bed is not intended as a "final destination" for the patient – a plan for discharge is required on admission. Individuals appropriate for CC are medically stable (diagnosis and acute phase complete), but have multiple complex chronic conditions requiring daily skilled assessment by an interprofessional team. Lengths of stay are targeted in a range of 45-90 days, with clear goals set, in order to enable appropriate care to be provided at home or at a different level (e.g. LTC or supportive housing). OVERALL ADMISSION CRITERIA = 1) Need daily skilled assessment by an interprofessional team. 2) Medically stable: i) The major portion of diagnostic tests for the patient has been completed and the patient is not requiring acute daily medical intervention by a physician. ii)The patient has completed the acute phase of illness. iii) Clearly defined goals have been established (including a date of discharge). iv) Criteria identified in the definition have been met.
Long-Term Care Homes Act, 2007	Convalescent Care Eligibility Criteria	Same, short-stay admission, respite care and convalescent care programs 156. (1) A placement co-ordinator shall determine a person to be eligible for long-term care home admission as a short-stay resident in the respite care program only if, (a) the person, (i) has a caregiver who requires temporary relief from his or her caregiving duties, or (ii) requires temporary care in order to continue to reside in the community and is likely to benefit from a short stay in the home; (b) it is anticipated that the person will be returning to his or her residence within 60 days after admission to the long-term care home; and (c) the person meets the requirements of clauses 155 (1) (a), (b), (c) and (e).

Source	Definition	Description
		(2) A placement co-ordinator shall determine a person to be eligible for long-term care home admission as a short-stay resident in the convalescent care program only if, (a) the person requires a period of time in which to recover strength, endurance or functioning and is likely to benefit from a short stay in a long-term care home; (b) it is anticipated that the person will be returning to his or her residence within 90 days after admission to the long-term care home; and (c) the person meets the requirements of clauses 155 (1) (a), (b), (c) and (e).
HNHB LHIN Restorative Care Bed Review: Final Report and Recommendations April 2013	Convalescent Care Program	The Convalescent Care Program (CCP) is a short-stay program for persons who need time to recover strength, endurance or functioning and who are anticipated to return to their residences after admission to the CCP. The maximum CCP stay that can be authorized by the CCAC for an eligible person is up to 90 continuous days at one time, with a total maximum of 90 days in a calendar year. (Source: MOH-LTC Policy for the Operation of Short-Stay Beds July 1, 2010) Target LOS = 45 days
Transitional Care Program Framework - Health System Performance and Accountability Division MOHLTC (August 2010)	Convalescent Care	Beds in Long-Term Care Homes or Retirement Homes that are licensed and approved by the Ministry. The home must meet the legislated requirements under the Long-Term Care Homes Act. These beds are provided to an individual who requires a period of time in which to recover strength, endurance or functioning and who are likely to benefit from a short-stay (up to 90 days) in a Long-Term Care Home before returning home. The Convalescent Care Program expands the range of options for individuals who do not need acute care but cannot yet manage at home; these individuals may be coming directly from hospital or may be living in the community. CCACs are the gatekeepers to the Convalescent Care Program.
Admission to Long Term Care Homes Community Care Access Centres - Community Care Access Centres Client Services Policy Manual Ministry of Health and Long Term Care (nd)	Convalescent Care Program/ Supportive Care Program	The primary focus of the program is to provide a supportive environment for people discharged from acute care settings who need to recover their strength; endurance and functioning before returning home. The Convalescent Care Program is a time-limited LTC home placement. Although there may be monitoring by the case manager on an ongoing basis, from a data perspective, the person is a resident of the LTC home and not a Community Care Access Centre (CCAC) in-home client. The Convalescent Care Program operates under the current legislation and regulations and is available to individuals coming from either the community or hospital. It must be anticipated

Source	Definition	Description
Retrieved on Sept, 11, 2013 from http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm_sec_11/11-10.html		that the person will return to his or her residence within 90 days after admission. Convalescent care residents could include individuals recovering from surgery or an illness, such as cancer, or those with an impairment or disability. Some residents could be preparing for active rehabilitation before returning home. Others could have non-acute clinical conditions and need short-term, 24-hour professional attention (e.g., intensive wound care). The level of medical need of a LTC home's convalescent care residents is determined by what the LTC home is able to provide. What all these populations have in common is the need for short-term care before returning home; specific populations will vary according to the community and LTC home. The care provided to convalescent care residents has a greater focus on reactivation in preparation for returning home. The program's philosophy is based on promoting self-care and self-sufficiency, emphasizing adaptation to the current situation, and drawing on the individual's abilities and strengths. Therefore, the individuals best suited to the program are motivated to return home, committed to participating in activities that will make this possible, and capable of learning. The individuals should have goals and timeframes that are clear, realistic, and able to be monitored. The program is not for individuals who need permanent LTC home admission, complex continuing care or palliative care. **Convalescent Care Program – Eligibility Criteria** s. 131(2) An applicant shall be determined to be eligible for admission to a nursing home as a short-stay resident in the supportive care program if, and only if, (a) the applicant requires a period of time in which to recover strength, endurance or functioning and is likely to benefit from a short-stay in a nursing home; (b) it is anticipated that the applicant will be returning to his or her residence within 90 days after admission to the nursing home; and (c) the applicant meets the requirements of clauses 130 (1) (a), (b), (c) and (e). s. 130(1) An applicant shall be determined to be eligible for admission to a nursing home if, and only if, (a) the applicant is at least 18 years old;

Source	Definition	Description
		(b) the applicant is an insured person under the Health Insurance Act; (c) the applicant meets at least one of the conditions set out in subsection (2); . . . (e) the applicant's care requirements can be met in a nursing home. s. 130(2) The following are the conditions referred to in clause (1) (c) : 1. The applicant requires that nursing care be available on-site 24 hours a day. 2. The applicant requires assistance each day with activities of daily living. 3. The applicant requires, at frequent intervals throughout the day, on-site supervision or onsite monitoring ensuring his or her safety or well-being. 4. The applicant is at risk of being financially, emotionally or physically harmed if the applicant lives in his or her residence. 5. The applicant is at risk of suffering harm due to environmental conditions that cannot be resolved if the applicant lives in his or her residence. 6. The applicant may harm someone if the applicant lives in his or her residence. Note: There is no requirement to examine the availability of publicly-funded community-based services or other available arrangements when determining a person's eligibility for short-stay convalescent care. Since this program's **primary focus is to assist in relieving pressures within the acute care setting**, there is an expectation that, within 24-72 hours of having been identified in either the community or hospital, an individual is assessed, eligibility is determined, goals are identified, and a tentative date for discharge from convalescent care is set. The RAI-HC is the assessment instrument used for the functional assessment of convalescent care applicants, although a somewhat abbreviated version is used for applicants from hospital.

Source	Definition	Description
Transitional Care Program Framework - Health System Performance and Accountability Division MOHLTC (August 2010)	Restorative Care	A program which provides specialized restorative care focused on returning individuals to their highest level of independence in the community. Includes both hospital and community based programs (i.e. CCC, Rehab, or Convalescent Care – see page 6 for definitions).
Restorative & Convalescent Care Final Report (SWLHIN). April 2013 Retrieved from http://www.southwestlhin.on.ca/uploadedFiles/Public_Community/Current_Initiatives/Access_to_Care/RC%20CC%20Final%20Report%20April%2017%20v6.pdf on September 23, 2013	Restorative Care	Defined as a period of minimal care and increasing physical activity necessary to restore clients to functional and cognitive health and allow their return to a useful and productive life to the extent of their abilities
An Integrated Program for Complex Care in the Hamilton Niagara Haldimand Brant Local Health Integration Network Final Report from the Task Group on Coordinated Strategy for Complex Care to the Hamilton Niagara Haldimand Brant Local Health Integration Network Board of Directors Approved June 29, 2010	Restorative Care Stream (Complex Care)	People with a multiple medical and/or functionally complex condition(s) who are expected to benefit from low intensity, long duration interventions provided by an interprofessional team, with clearly articulated functional improvement goals that can be attained within the average length of stay a) Mini-mental state exam (MMSE) score of >16 b) Presence of significant physical/functional impairments c) Physical tolerance that permits participation in programming d) Goal to go home or to a retirement home. Target LOS = 45-60

Source	Definition	Description
Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies, Health Services Restructuring Commission, 1997 Retrieved on Sept. 24, 2013 from http://www.ontla.on.ca/library/repository/mon/1000/10268030.pdf	"Reactivation" services	A significant sub-category of sub-acute care, currently delivered in some Ontario long term care and chronic care facilities. These services are directed at patients who suffer some cognitive impairment and will require a "relatively" brief period of intense therapy to regain optimal function. They do not require stroke rehabilitation or intensive programs of geriatric rehabilitation and many of these patients will return to their homes in the community while others will eventually live in a long term care facilities.
Transitional Care Program Framework - Health System Performance and Accountability Division MOHLTC (August 2010)	Reactivation/ Restoration - Complex Continuing Care	A nursing care unit where the beds are designated for the provision of care for patients who have experienced a recent decline in their independent functions due to progressive debilitation and/or physical de-conditioning; who require a short period of enhanced care but have a discharge goal of home or Long-Term Care Home.
Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies, Health Services Restructuring Commission, 1997 Retrieved on Sept. 24, 2013 from http://www.ontla.on.ca/library/repository/mon/1000/10268030.pdf	Sub-Acute Care	• Sub-acute care is a discrete level of service for patients who do not require acute services but who do require separate and distinct goal-oriented inpatient services, such as skilled therapy or nursing care, on a short-term basis, to regain function and return home. • Sub-acute patients may require: o treatment and/or assessment of the care plan by a physician o ancillary or technological services such as laboratory, pharmacy, nutrition and diagnostics o therapy and rehabilitation services (i.e., physiotherapy, occupational therapy, etc.). • Sub-acute care can vary from wound management to the care required by patients on ventilators or with progressive neurologic impairments. • Sub-acute ranges from highly intensive services in the early days to less intense services as people regain function. It includes the bridging period before the patient returns home, during which time services focus on building confidence, stamina and strength. • Sub-Acute Patient Population - Sub-acute care can be used to serve a wide range of patients of all ages, including people who need post-surgical care, cancer care, cardiac care/rehabilitation,

Source	Definition	Description
		AIDS care, care for head injury, joint replacement, rehabilitation, high-tech intravenous therapy, ventilator care, pediatric care, enteral care, physical therapy, occupational therapy and speech therapy. Experience with sub-acute programs in the United States and Alberta indicate that, as with many other health care services, the largest users of this service are the elderly. In general, patients who would benefit from sub-acute care: ○ have passed the acute, unstable part of their illness and need further support and treatment ○ have an illness, such as congestive heart failure, that does not require acute care ○ typically need three to five hours of therapeutic services daily to help them recover and regain function ○ depending on their condition, will need sub-acute care for an average of seven to 60 days to regain function. • Admission criteria for sub-acute care could include the following: ○ patients who are medically stable and unlikely to deteriorate to a more acute level of illness ○ patients who will be able to learn and actively participate in treatment or convalescence ○ patients who will need ongoing daily monitoring by a physician, with specialists visiting once a week ○ patients who lack the ability to safely manage the activities of daily living at home at the time of illness or discharge from an acute care facility ○ patients who will return "home" (i.e., LTC facility, assisted living facility, private home) ○ patients who have an anticipated length of stay between seven and 60 days. The task force stressed the need to distinguish between services for patients who need more time and special services to recover from an illness and return home (sub-acute), and those who need extra care to regain enough function to make the transition to ongoing care either in the community or in a long term care facility (transitional).

Source	Definition	Description
Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies, Health Services Restructuring Commission, 1997 Retrieved on Sept. 24, 2013 from http://www.ontla.on.ca/library/repository/mon/1000/10268030.pdf	Transition to independent living programs	Transitional living enables individuals to develop the skills needed to make the transition from an institutional environment to living independently in the community. Patients with acquired brain injury, spinal cord conditions, amputations, traumatic conditions, stroke and other neurological conditions will be the primary candidates for transition to independent living programs. The length of stay for transition to independent living spaces is approximately 252 days. Siting: These programs should be located in community settings, geared to assisting people achieve independent living, and will be planned specifically for pediatric, adult and geriatric patient
Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies, Health Services Restructuring Commission, 1997 Retrieved on Sept. 24, 2013 from http://www.ontla.on.ca/library/repository/mon/1000/10268030.pdf	Transitional care	• A program, not a discrete level of care that offers care to those who do not require acute or sub-acute care but require activation and related therapeutic services to maintain physical and cognitive functioning to a level appropriate for the delivery of ongoing long term care services either in the community or in a facility-based environment. • This level of care would not be needed if adequate capacity were available elsewhere, and if providers were paid according to need. (i.e., People in the transitional category could be cared for in a long term care facility except that, within current programs and funding, those settings cannot provide the number of hours of nursing care or the distinct services they need to regain some function and health. For example, ALC patients in an acute care setting can receive between 2 and 3.8 hours of nursing care/day, while most long term care facilities are funded to provide only 1.5 to 2.5 hours of nursing care/day) • Transitional care is a program. It is not a discrete level of care. • Patients in transitional care usually need long term care. • Patients are suitable for reactivation/functional enhancement, etc. but at a level less intense than acute or sub-acute care. • These patients may also require acute/sub-acute care at intervals. • Transitional care programs are facility based, and may be housed within an acute care facility but not use acute care beds; or they could be sited in long term care or chronic care settings

Source	Definition	Description
		with reasonable access to acute care. Acute care may be required for such patients from time to time and should be readily accessible.
Transitional CareProgram Framework - Health System Performance and Accountability DivisionMOHLTC (August 2010)	Transitional Care Beds	Net new beds, established in hospitals subsequent to July 2008, funded through the Aging at Home/LHIN Urgent Priorities Funding, targeted towards ALC patients in acute/post-acute care that provide specialized restorative care focused on returning individuals to their highest level of independence in the community.These beds must have specific criteria for admission, a length of stay target, a clear plan of care with specific goals, and a discharge plan with home as the primary discharge site where feasible. These beds must support the achievement and maintenance of optimal levels of functioning and independence as primary outcomes that must be measured and reported.
Transitional Care Program Framework - Health System Performance and Accountability Division, MOHLTC (August 2010)	Transitional – hospital (Complex Continuing Care)	A nursing unit where the beds are designated for the provision of care for patients who no longer require acute/rehabilitation hospital inpatient services but still have medical issues and are not yet ready for discharge home and/or who are awaiting supportive placement.
Definitions by Patient Population		

Source	Definition	Description
HNHB LHIN Restorative Care Bed Review: Final Report and Recommendations April 2013	Debility / Medically Complex Rehabilitation Program	A progressive, dynamic, goal-oriented and time-limited process, which enables an individual with impairment to identify and reach his/her optimal mental, physical, cognitive and/or social functional level. Rehabilitation provides opportunities for the individual, the family and the community to accommodate a limitation or loss of function and aims to facilitate social integration and independence. The patient is in need of an interdisciplinary rehabilitation program. (Source: WHO & HNHB LHIN Rehab Task Group March 14 2011)
An Integrated Program for Complex Care in the Hamilton Niagara Haldimand Brant Local Health Integration Network Final Report from the Task Group on Coordinated Strategy for Complex Care to the Hamilton Niagara Haldimand Brant Local Health Integration Network Board of Directors Approved June 29, 2010	Medically Complex Stream (Complex Care)	People with multiple medically complex conditions such as complex wounds, ALS, MS, bariatric or COPD who require unique programming. Some distinct cohorts of this group include but are not limited to: a) Ventilator-dependent: People with CC needs that require specialized care and equipment to support their long term ventilation needs. This patient group requires highly specialized care and equipment b) Dialysis: People who have medically complex conditions and care needs that include hemodialysis c) ABI: People who require ongoing medical and therapeutic intervention to optimize and sustain their functional ability d) Life expectancy of > 3 months. LOS = 60-90 days
Definitions Related to Outpatient Rehabilitative Care		
Outpatient Rehabilitation in the GTA: Understanding the Current State (GTA Network, June 2011)	Outpatient Rehabilitation Service	An outpatient rehabilitation service where assessment and/or treatment are offered over a time-limited encounter with a goal specific to the limited scope of services offered. Assessment and treatment within specialty clinics may include such services as: (1) Assessment, prescription, and/or fitting/training for a specific equipment, assistive device, or orthotic/prosthetic (e.g. seating and positioning, communication device); (2) Assessment and/or intervention for a specific, localized body part/area (e.g. facial retraining, hand therapy); (3) Assessment and/or intervention for a specific functional impairment (e.g. memory, spasticity). Note that for the purpose of this analysis, only those clinics that provided both assessment and intervention were included.

Source	Definition	Description
Outpatient Rehabilitation in the GTA: Understanding the Current State (GTA Network, June 2011)	Outpatient Rehabilitation Service - Single Service	An outpatient rehab service located in acute care hospitals, rehab hospitals and community health centres/clinics that is suitable for individuals who are in need of an outpatient rehabilitation service in a single specialty area/profession. Clients may receive more than one rehab service; however, the services are not provided by way of a coordinated rehab approach. Services may include assessment only or assessment and treatment. Services may be provided during a one-time visit or multiple visits.
Outpatient Rehabilitation in the GTA: Understanding the Current State (GTA Network, June 2011)	Outpatient Rehabilitation Service (dedicated inter-professional team)	Outpatient rehab provided by an interprofessional team with expertise in the treatment and assessment of a particular patient population. Outpatient dedicated interprofessional teams are located in acute care hospitals, rehab hospitals and community health centres/clinics. They provide rehab to patients who require more than one rehab service and a coordinated rehab approach.
Outpatient Rehabilitation in the GTA: Understanding the Current State (GTA Rehab Network, June 2011)	Outpatient Rehabilitation Service (Mixed population inter-professional team)	Outpatient rehab that is provided by an interprofessional team, which typically assesses and treats patients from a variety of patient population groups. Outpatient mixed population interprofessional teams are located in acute care hospitals, rehab hospitals and community health centres/clinics. They provide rehab to patients who require more than one rehab service and a coordinated rehab approach.
Managing the Seams: Making the Rehabilitation System Work for People - The Rehabilitation Reform Initiative Prepared by: Provincial Rehabilitation Reference Group, March 2000 (Revised August 2000)	Ambulatory, Facility-Based	These services are provided at a facility (such as a hospital or rehabilitation facility) on an ambulatory basis.

Source	Definition	Description
Rehab Definitions Initiative Final Report March 2010, GTA Rehab Network	Community Rehabilitation Service (Single Service)	Individual rehab services that are usually provided through Community Care Access Centres. Single rehab services are suitable for individuals who are in need of one or more rehabilitation services in single specialty area(s)/profession(s) provided in the home, school or work environment. Although clients may receive more than one service, a coordinated approach is not used as rehab providers typically work as individual providers. However, some communication with other health providers may occur on an as-needed basis.
Rehab Definitions Initiative Final Report March 2010, GTA Rehab Network	Outpatient /Ambulatory Rehabilitation Service (Single Service)	An outpatient rehab service located in acute care hospitals, rehab hospitals and community health centres/clinics that is suitable for individuals who are in need of an outpatient rehabilitation service in a single specialty area/profession. Clients may receive more than one rehab service; however, the services are not provided by way of a coordinated rehab approach. Services may include assessment only or assessment and treatment. Services may be provided during a one-time visit or multiple visits.
Other Definitions		
Inpatient Rehabilitationin Canada, 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Most Responsible Health Condition	The primary etiological diagnosis that describes the most significant condition leading to the client's rehabilitation stay. Where multipleconditions exist, it is the one health condition that is most related to the RehabilitationClient Group and the condition that most of the resources are directed towards (seeRehabilitation Client Group).
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Rehabilitation Client Group (RCG)	The condition that best describes the primary reason for the client's admission to the rehabilitation program. The rehabilitation team determines the RCG at the time of admission. The complete list of RCGs can be found in Appendix C of the Rehabilitation Minimum Data Set Manual produced and distributed by CIHI.
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Definition of Rehabilitation Client Group (RCG)	The health condition that best describes the primary reason for admission to the rehabilitation program. The appropriate Rehabilitation Client Group is determined at the time of admission by the rehabilitation team and can be modified at discharge if necessary.

Source	Definition	Description
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	RCG - Medically Complex	Includes cases with multiple medical and functional problems and complications prolonging the recuperation period. Medically complex cases require medical management of a principal condition and monitoring of co-morbidities and potential complications. Rehabilitation treatments are secondary to the management of the medical conditions. The Medically Complex RCGs group clients by the program/treatment focus rather than the aetiology.
Inpatient Rehabilitation in Canada 2003–2004. Special Topic: A Look at the Older Population (CIHI, 2005)	RCG - Debility	Includes cases where clients are generally de-conditioned and there may not be aspecific aetiology associated with the decline in function. Includes only clients who are debilitated for reasons other than cardiac or pulmonary conditions.
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Assessment	The grouping of administrative and clinical information that is collected for an inpatient rehabilitation client and is submitted to the NRS at admission, discharge and follow-up.
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Date Ready for Admission	The date on which the client meets criteria for admission to the rehabilitation facility and is considered ready to start a rehabilitation program. It does not refer to the date the client is put on a waiting list if this is done prior to when the client is clinically ready for rehabilitation.
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Date Ready for Discharge	The calendar date that the client is considered ready for discharge from the rehabilitation program. On this date the client meets criteria for discharge according to the rehabilitation team and has met all or most of the rehabilitation goals set for them.
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Days Waiting for Admission	The date on which the client is admitted to the rehabilitation facility minus the Date Ready for Admission, measured in days.

Source	Definition	Description
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Discharge Assessment	The client assessment that is completed within 72 hours of discharge from the rehabilitation program.
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Episode	For the purposes of the NRS, an episode is an inpatient rehabilitation stay that is recorded by both an admission NRS assessment and a discharge NRS assessment. The analyses in the NRS reports are based on rehabilitation episodes. Exception: Clients recorded as having an (Un) planned discharge are still considered to have had a rehabilitation episode in the NRS (see (Un) planned Discharge).
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Facility	Refers to the site where the rehabilitation beds are grouped and represents the level at which hospitals submit data for the NRS. Often, “facility” is synonymous with “hospital”. For hospitals with more than one site or location, there may be more than one NRS facility within a hospital corporation.
InpatientRehabilitationin Canada 2003–2004Special Topic:A Look at the Older Population (CIHI, 2005)	Follow-up Assessment	The client assessment that is collected between 80 and 180 days after discharge from the rehabilitation program.
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Length of Stay	The number of days between the date on which the client is admitted to the rehabilitation facility and the date on which the client is discharged from the rehabilitation facility. Any days on which the client could not participate in the rehabilitation program due to a health reason are excluded from the calculation.
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Length of Stay (LOS) Efficiency	The change in Total Function Score (see Total Function Score) per day of client participation in the rehabilitation program. Calculated as Total Function Score divided by the LOS (see Length of Stay).

Source	Definition	Description
Managing the Seams: Making the Rehabilitation System Work for People - The Rehabilitation Reform Initiative Prepared by: Provincial Rehabilitation Reference Group, March 2000 (Revised August 2000)	Siting (Of Services)	Definition: The physical location of the rehabilitation service provider. Where rehabilitation services are provided has implications both for their accessibility to the client, and for their cost to the payer. Rehabilitation services can be facility-based, and within hospitals, provided through in-patient or ambulatory programs; delivered through private practice providers' offices; or delivered to the client within the client's home or residence, place of work, school, or local recreational centre.
Outpatient Rehabilitation in the GTA: Understanding the Current State (GTA Rehab Network, June 2011)	Wait time	Wait time, in days, from referral date to date of first therapy appointment
Inpatient Rehabilitation in Canada 2003–2004, Special Topic: A Look at the Older Population (CIHI, 2005)	Interventions, Rehabilitation	A set of activities that are provided to a client aimed at improving/maintaining the client's health status and minimizing the impact of impairments and disabilities on the client's quality of life.
Rehab Definitions Initiative Final Report March 2010, GTA Rehab Network	Dedicated Rehab Unit	An inpatient rehab unit located in acute care and rehab hospitals that serves a single patient population group and provides intensive rehabilitation. Some units may specialize in more than one diagnosis in related populations (e.g. Cardio/Respiratory, Orthopaedic/Amputation, etc.). A dedicated rehab unit is suitable for individuals who require 24-hour hospital care and who are in need of an interprofessional rehab program using a coordinated rehab approach.
Managing the Seams: Making the Rehabilitation System Work for People - The Rehabilitation Reform Initiative Prepared by: Provincial Rehabilitation Reference Group, March 2000 (Revised August 2000)	Length of Time Service is Needed	The length (duration) of the rehabilitation process that is required to enable a client to meet activity and participation goals. Time is an important factor in the allocation of rehabilitation resources. Some impairments will require a 'time-limited' period of rehabilitation in order for clients to meet their activity and participation goals. For other impairments, rehabilitation may be long-term or even life-long in order for these goals to be reached. For yet another group, the need for rehabilitation may be only periodic or intermittent. There is no direct correspondence between the cause of an individual's impairment (e.g. stroke) and the expected duration of the rehabilitation process. Rather, the relationship lies with the complexity of all aspects of client need (see above), their determinants of health and the rehabilitation service provided.

Source	Definition	Description
		Depending on the nature of an individual's rehabilitation needs, a variety of service delivery configurations can be put in place. For example, the best means of ensuring timely access to rehabilitation services will vary, depending on whether a client's needs are acute, continuing or episodic in nature, as well as the severity of impairment involved. Similarly, the intensity of the case management system used to follow an individual through the rehabilitation process would vary according to whether the client's needs were acute, continuing or episodic.