APPENIDIX B: ADDITIONAL ACUTE AND POST-ACUTE INPATIENT REHABILITATIVE CARE CONSIDERATIONS

Conditions typically requiring rehabilitative care		
Condition	**Additional rehabilitative care considerations**	**Source**
Acquired brain injury (ABI)	• Every individual with traumatic brain injury should have ***timely, specialized, interdisciplinary rehabilitation services.*** • To achieve optimal efficiencies of inpatient rehabilitation, individuals with traumatic brain injury should receive ***a minimum of three hours per day of therapeutic interventions,*** ensuring focus on cognitive tasks.	Clinical Practice Guideline for the Rehabilitation of Adults with Moderate to Severe Traumatic Brain Injury (October 2016)
Amputee	• Best practices for care of patients with amputated limbs recommend ***rehabilitation through all levels of care, pre-and post-op,*** with care following the patient and delivered during inpatient care and into the community. • Early assessment and planning of rehabilitation can commence at pre-op stage and helps to prepare the patient for rehabilitation. A pre-amputation consultation also enables the physiotherapist to give appropriate advice, information and reassurance; issues such as phantom limb sensation and avoidance of falls may be discussed.	British Association of Chartered Physiotherapists in Amputee Rehabilitation, Clinical guidelines for the pre- and post-operative physiotherapy management of adults with lower limb amputation, 2nd Edition, 2016
Burns	• Burn therapy starts immediately or as soon after presentation for treatment as possible and continues till scar maturation which is commonly 12-18 months.	ACI Statewide Burn Injury Service, Physiotherapy and Occupational Therapy Clinical Practice Guidelines, July 2014.

Conditions typically requiring rehabilitative care		
Condition	**Additional rehabilitative care considerations**	**Source**
	The time to reach scar maturity varies between individuals.	
	• An interdisciplinary burn rehab team provides intensive rehabilitation care to patients who require 24-hour hospital care and have ongoing, complex rehab and surgical needs and/or infection control issues.	GTA Rehab Network. Burn Rehab Definition Framework. May 2010
Chronic obstructive pulmonary disease (COPD)	• Pulmonary rehabilitation is recommended for the management of moderate to severe chronic obstructive pulmonary disease (COPD) in stable patients and for patients following an acute exacerbation (within one month of hospital discharge) at an accessible and clinically appropriate location (inpatient, outpatient, community or home). • COPD patients who have completed pulmonary rehabilitation are recommended to transition to an exercise program to support the maintenance of functional gains.	Health Quality Ontario; Ministry of Health and Long-Term Care. Quality-Based Procedures: Clinical Handbook for Chronic Obstructive Pulmonary Disease (Acute and Post-acute), (February 2015). February 2015. 88 p.
Congestive heart failure / coronary arterial disease (CHF/CAD)	• Cardiovascular rehabilitation (CR) is an important specialized component of chronic cardiovascular disease care and chronic disease management that uses a multifaceted approach focused on: reducing cardiovascular risk factors, using behaviour modification strategies to sustain healthy lifestyles and promote pharmacological adherence, and providing therapeutic exercise training.	Cardiac Care Network. Standards for the Provision of Cardiovascular Rehabilitation in Ontario. Sept 2014
Geriatric	• Geriatric rehab improves functional outcomes, reduces nursing home admissions and mortality.	Achterberg WP, Cameron ID, Bauer JM, Schols JM. (2014) Geriatric Rehabilitation: State of the Art and

Conditions typically requiring rehabilitative care		
Condition	**Additional rehabilitative care considerations**	**Source**
	• There is strong evidence that using an interprofessional approach with team coordination and care planning is effective. Team members should include geriatricians, nurses, physiotherapists, occupational therapists, speech therapists and social workers.	Future Priorities. JAMDA 20 396-398. https://doi.org/10.1016/j.jamda.2019.02.014
	• Goal-setting together with the patient is an essential aspect of geriatric rehabilitation.	Van Seben, R., Reichardt, L., Smorenburg, S., & Buurman, B. (2017). Goal-setting instruments in geriatric rehabilitation: a systematic review *J Frailty Aging*. Chapter 7. Vol. 6, DOI: 10.14283/jfa.2016.103
	• The RCA Frail Seniors Rehabilitative Care Best Practice Framework outlines best practices for the rehabilitative care of frail seniors across the continuum. The cross-continuum information is organized under two categories: o Processes of care. These refer to evidence-based actions or interventions performed during the delivery of patient care. o Clinical areas that are specific to the care of frail seniors	RCA Frail Seniors Rehabilitative Care Best Practice (2020)
	• Rehabilitation using a comprehensive geriatric assessment approach is an effective intervention that can serve to reduce mortality and improve functional outcomes for hospitalized, frail older adults. • Geriatric rehabilitation should begin at admission (and continue beyond discharge as needed) and involve	Stott DJ, Quinn TJ. (2017) Medicine in older adults. Principles of rehabilitation of older adults. *Medicine*. Volume 45, Issue 1, January 2017, Pages 1-5, DOI: https://doi.org/10.1016/j.mpmed.2016.10.002

Conditions typically requiring rehabilitative care		
Condition	**Additional rehabilitative care considerations**	**Source**
	multiple disciplines who use an interprofessional approach with the patient to deliver holistic, individual rehabilitative care.	
	• Older people in contact with health care professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall(s). • Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be: o Offered an individualized, multifactorial falls risk assessment performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service. o Observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.	NICE Guideline: Falls in older people: assessing risk and prevention (June 2013)
	• The SF7 Toolkit is a Senior Friendly Care (sfCare) resource that supports clinical best practices for healthcare providers across the sectors of care. It also includes self-management tools for older adults and their caregivers. The toolkit focuses on seven clinical areas that support resilience, independence, and quality of life and includes information for particular sectors of care: o Delirium (p. 6-10, in hospital p.13)	Regional Geriatric Program of Toronto. Senior Friendly Care SF7 Toolkit, v2 2019

Conditions typically requiring rehabilitative care		
Condition	**Additional rehabilitative care considerations**	**Source**
	○ Mobility (p. 18-22, in hospital p. 25) ○ Continence (p. 30-34, in hospital p.37) ○ Nutrition (p. 42-45, in hospital p.48) ○ Pain (p. 53-57, in hospital p.60) ○ Polypharmacy (p. 66-71, in hospital p.74) ○ Social Engagement (p. 79-82, in hospital p. 85)	
	The Senior Friendly Care Framework includes the following defining statements related to Senior Friendly processes of care: • Assessment is holistic and identifies opportunities to optimize the physical, psychological, functional and social abilities of older adults. • Care addresses the physical, psychological, functional and social needs of older adults. • Care is guided by evidence-informed practice. • An interprofessional model of care is preferred especially when older adults are frail. • Care is integrated and provides continuity, especially during transitions. • Goals of care may include recovery from illness, maintenance of functional ability and preservation of the highest quality of life as defined by the individual. • Older adults are partners with the care team. • Care is flexible and aligned with an individual's preferences. • Communications and clinical and administrative processes are adapted to meet the needs of older	Regional Geriatric Program of Toronto. Senior Friendly Care. 2019

Conditions typically requiring rehabilitative care		
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	adults. • Older adults are provided information in a way that makes it easy to understand so that they can make informed decisions.	
	• Evidence-based approaches to geriatric care (including interdisciplinary comprehensive geriatric assessment and comprehensive individualized care plans, informed by assessment of geriatric syndromes) improve health outcomes, and are associated with improved independence, decreased lengths of stay and decreased rates of re-hospitalization. • Formalized and evidence-based cross-sectoral partnerships and clinical pathways help facilitate timely access to the right care in the right place, and are associated with decreased wait times, decreased lengths of stay and a decrease in ALC days.	Provincial Findings from MOHLTC Assess and Restore Funded Projects: 2014/15 Summary 2015/16 Summary 2016/17 Summary 2017/18 Summary 2018/19 Summary
	• Age-related hearing loss typically begins in individuals who are in their forties; however, the sharpest rise occurs in those over the age of 80, with 50% to 80% of individuals in this range being affected. • Hearing loss is associated with many biopsychosocial consequences including: accelerated cognitive decline, depression, increased risk of dementia, falls, poorer balance, hospitalizations, reduced communication function, social isolation, loss of autonomy, reduced driving ability and financial decline.	Davis, A., McMahon, C.M., Pichora-Fuller, K.M., Russ, S., Lin, F., Olusanya, B.O., Chadha, S., & Tremblay, K.L. (2016). Aging and Hearing Health: The Life-course Approach. *Geronotologist*, Vol. 56, No. S2, S256–S267, https://doi.org/10.1093/geront/gnw033

Conditions typically requiring rehabilitative care		
Condition	**Additional rehabilitative care considerations**	**Source**
	• Rehabilitative care through audiology services can optimize functioning and reduces distress and social isolation. Audiology intervention can include aural rehabilitation, the provision of assistive hearing devices, perceptual training and education, and counselling on how to use devices and modify environments to optimize the listening experience.	
Hip fracture	• All hip fracture patients are to receive an active rehabilitation program following discharge from acute care. • Post-acute rehab is to begin no later than Day six post-surgery and may occur in: o Bedded settings: inpatient rehabilitation and complex continuing care o Community-based settings: rehabilitation in the home or through outpatient physiotherapy clinics o LTC homes in the case of patients admitted from LTC. • Hip fracture patients who are medically stable, cognitively intact, and able to mobilize short distances benefit from early supportive discharge home to receive a community-based rehabilitation program.	Health Quality Ontario; Ministry of Health and Long-Term Care. Quality-Based Procedures: Clinical Handbook for Hip Fracture Health Quality Ontario & Ministry of Health and Long-Term Care (May 2013). Toronto, ON: Health Quality Ontario; 2013 May. 97
	• Quality Standard: "Patients with hip fracture participate in an interdisciplinary rehabilitation program (in an inpatient setting, a community setting, or a combination of both) with the goal of returning to their	Healthy Quality Ontario (2017) Hip Fracture Quality Standards

Conditions typically requiring rehabilitative care		
Condition	**Additional rehabilitative care considerations**	**Source**
	pre-fracture functional status." • Rehabilitative care programs have been shown to improve patient outcomes, including functional status, leg strength, health status, balance, mobility, instrumental activities of daily living and social functioning. • On discharge from the acute care hospital, all hip fracture patients, including patients with cognitive impairment and those residing in long-term care homes, should have the opportunity to participate in an active interdisciplinary rehabilitation program.	
	• See RCA Rehabilitative Care Best Practice Guidelines Framework for Patients with Hip Fracture for additional specific recommendations pertaining to home and ambulatory rehabilitative care.	Rehabilitative Care Alliance (2018) Rehabilitative Care Best Practice Guidelines Framework for Patients with Hip Fracture
Oncology	• Rehab patients with a good prognosis who require inpatient rehab and whose primary rehab needs are to address general deconditioning pre- or post-cancer surgery/treatment should be referred and transferred directly to a mixed rehab program. • Rehab patients with multiple medical and rehab needs should be referred and transferred to a rehab program with a dedicated oncology team. • Some patients may require a slower-paced rehab program for a longer duration to maximize rehab potential (e.g., patients undergoing chemotherapy treatment).	GTA Rehab Network. Oncology Rehab Definition Framework. June 2009

Conditions typically requiring rehabilitative care		
Condition	**Additional rehabilitative care considerations**	**Source**
	• Up to 75% of people with cancer experience cognitive problems during treatment; 35% have issues that continue for months after finishing treatment. These problems vary in severity and often make it hard to complete daily activities. • Cognitive rehabilitation and cognitive training is recommended to help patients improve their cognitive skills and find ways to cope with cognitive problems. • Occupational therapy and vocational rehabilitation is recommended to help people with the activities of daily living and job-related skills.	American Society of Clinical Oncology. Attention, Thinking, or Memory Problems. Approved by the Cancer.Net Editorial Board 04/2018
Shoulder arthroplasty	• Bedded rehabilitative care typically is not recommended. An outpatient ambulatory rehabilitative care setting is recommended.	Rehabilitative Care Alliance (2019) Rehabilitative Care Best Practice Guidance for Patients Post Shoulder Arthroplasty
Spinal Cord Injury	• The "ideal" scenario for modern SCI care is thought to be treatment in specialized, integrated centres with an interdisciplinary team of health care professionals providing care as early as possible following injury and throughout the rehabilitation process, including appropriate discharge to the community with ongoing outpatient care and follow-up.	Spinal Cord Injury Research Evidence
Stroke	• Patients with moderate or severe stroke who are rehabilitation-ready and have rehabilitation goals should be given an opportunity to participate in inpatient stroke rehabilitation. • Stroke patients should receive, via an individualized treatment plan, at least three hours of direct task-	Health Quality Ontario; Ministry of Health and Long-Term Care. Quality-Based Procedures: Clinical Handbook for Stroke (Acute and Post-acute), (December 2016) Toronto: Health Quality Ontario; 2016 December. 132 p

Conditions typically requiring rehabilitative care		
Condition	**Additional rehabilitative care considerations**	**Source**
	specific therapy per day by the interprofessional stroke team for at least six days per week. • Moderate Stroke: In general, patients who qualify for inpatient rehabilitation are those with an early AlphaFIM™ score of 40 to 80*. • Severe Stroke: Patients presenting to hospital with acute stroke, with early AlphaFIM™ score of <40 to be admitted to inpatient rehab (high or low intensity as tolerance permits).	
	• All patients with stroke admitted to hospital and who require rehabilitation should be treated in a comprehensive or rehabilitation stroke unit by an interdisciplinary team. Survivors of severe stroke should be reassessed at regular intervals for their rehabilitation needs.(National Best Practices-Ref 7, Pg15) • The benchmark for date of admission to inpatient rehab post stroke onset is seven days. (p 73)	Ontario Stroke Evaluation Report 2012 Network: Prescribing System Solutions to Improve Stroke Outcomes
Total joint replacement	• Inpatient rehabilitation should not be the first choice for the typical patient following total hip or knee replacement. The Orthopaedic Quality Scorecard indicates that no more than 10% of hip/knee replacement patients should require inpatient rehabilitation. • The timing, frequency and intensity of rehabilitative care services provided in a bedded level of care should be defined in consideration of functional tolerance and	Rehabilitative Care Alliance (2019) Rehabilitative Care Best Practice Framework for Patients with Primary Hip and Knee Replacement RCA Quick Reference Guide for Bedded Rehabilitative Care – Total Joint Replacement

Conditions typically requiring rehabilitative care		
Condition	**Additional rehabilitative care considerations**	**Source**
	goals of the patient. • See the complete RCA Guidelines or Quick Reference Guide on rehabilitative care for patients following hip and knee replacement for additional information on the best practice recommendations for initiation, duration, frequency and clinical considerations.	
	• Confirmation of discharge destination post surgery should be assessed in the pre-admission phase as there may be a few patients (i.e., ≤ 10%) who will require inpatient rehab. • There are numerous individual factors which can impact upon a patient's rehab trajectory following total joint replacement. Patients who might require inpatient rehab are those who present with a combination of concerns related to poor overall functioning/mobility, pre-operative risk factors or non-modifiable barriers in the home environment. (See Appendix A in Guideline for Pre-Admission Rehabilitative Care Processes: Primary, elective, unilateral total joint replacement.)	GTA Rehab Network, (2019) Guideline for Pre-Admission Rehabilitative Care Processes: Primary, elective, unilateral total joint replacement.