## APPENDIX C: ADDITIONAL IN-HOME AND AMBULATORY REHABILITATIVE CARE CONSIDERATIONS

| Conditions typically requiring rehabilitative care | | |
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| **Condition** | **Additional rehabilitative care considerations** | **Source** |
| **Acquired brain injury (ABI)** | • Individuals with ongoing disability after traumatic brain injury should have ***timely access to specialized outpatient or community-based rehabilitation*** to facilitate continued progress and successful community reintegration. (Adapted from New Zealand Guidance Group 2007, 6.6, p. 116) | Clinical Practice Guideline for the Rehabilitation of Adults with Moderate to Severe Traumatic Brain Injury (October 2016) |
| | • Provision of specialized, coordinated, interprofessional ABI home-based rehabilitation services to persons with ABI results in better outcomes than those who receive generic services. | Boschen K, Gerber G, Gargaro J. (2010) Poster 178: Comparison of Outcomes and Costs of 2 Publicly-Funded Community-Based Models of Acquired Brain Injury Services. Archives of Physical Medicine and Rehabilitation Vol 91 Issue 10, PE59 https://doi.org/10.1016/j.apmr.2010.07.208 |
| **Amputee** | • Best practices for care of patients with amputated limbs recommends ***rehabilitation through all levels of care, pre-and post-op*** with care following the patient and delivered during inpatient care and into the community.<br>• 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 |

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| **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. The time to reach scar maturity varies between individuals. | ACI Statewide Burn Injury Service, Physiotherapy and Occupational Therapy Clinical Practice Guidelines, July 2014. |
| | • An interdisciplinary burn rehab team in an outpatient/ambulatory setting is indicated when two or more of the following modalities are needed for more than two weeks: nursing pain management, pressure therapy, splinting skin care, social support (Psych/Counselling), PT/OT to maximize function, ongoing counselling and education specific to burn care.<br>• Services may include assessment only or assessment and treatment. Services may be provided during a one-time visit or multiple visits. | 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).<br>• A standardized pulmonary rehabilitation program is about 40 hours in total, with three sessions per week at 1.5 to 2 hours per session. The intensity and duration of PR programs are similar across outpatient hospital and community settings. | 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. |

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| **Condition** | **Additional rehabilitative care considerations** | **Source** |
| | • COPD patients who have completed pulmonary rehabilitation are recommended to transition to an exercise program to support the maintenance of functional gains, but parameters of delivery still need to be decided. | |
| **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.<br>• CR programs may operate in a stand-alone community setting or as part of a larger hospital system. CR services shall be provided through an integrated interprofessional team, led by a program manager<br>• CR for persons with established cardiovascular disease shall be provided to: (1) individuals with any of the following diagnoses: acute coronary syndrome, chronic stable angina, chronic stable heart failure; (2) following percutaneous coronary or valvular intervention; coronary artery bypass surgery; cardiac valve surgery; cardiac transplantation; ventricular assist device implantation. (p. 7)<br>• CR is also recommended for those who have not had a cardiovascular event but have cardiovascular risk factors | Cardiac Care Network. Standards for the Provision of Cardiovascular Rehabilitation in Ontario. Sept 2014 |

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| | (e.g. hypertension, diabetes, and hyperlipidemia) and are high risk for future cardiovascular events. (p. 7)<br>• There is emerging evidence that CR would also benefit patients with atrial fibrillation; peripheral artery disease; cerebrovascular disease and following cardiac resynchronization therapy. (p. 8) | |
| | • A systematic referral to community programs for cardiac rehabilitation is vital in improving patient's participation in supervised exercise programs.<br>• In order for patients to obtain optimal benefit from exercise programs, cardiac rehabilitation should commence within 30 days of hospital discharge.<br>• Cardiac rehabilitation is strongly recommended for patients with coronary artery disease particularly those with multiple modifiable risk factors. | Cardiac Care Network of Ontario & Ministry of Health and Long-Term Care. Quality-Based Procedures Clinical Handbook for Coronary Artery Disease. September 2014. |
| **Developmental disabilities** | • The best practice guidelines for the journey to adult life for youth with disabilities are broad and emphasize the key role of multidisciplinary teams, community supports and the importance of setting the goal of the child/youth's transition to be an active member in the community.<br>• The child/youth will need different supports at different times, though the focus is on using community and community supports as much as possible in order to provide the best transition and integration into their community | Stewart, D., et al. The Best Journey to Adult Life For Youth with Disabilities An Evidence-based Model and Best Practice Guidelines For The Transition To Adulthood For Youth With Disabilities, 2009 |

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| **Geriatric** | • 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.<br>• 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:<br>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<br>o Observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. | NICE Guideline:<br>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:<br>o Delirium (p. 6-10, home and community care p.11)<br>o Mobility (p. 18-22, home and community care p.23)<br>o Continence (p. 30-34, home and community care p.35)<br>o Nutrition (p. 42-45, home and community care p.46) | Regional Geriatric Program of Toronto. Senior Friendly Care SF7 Toolkit, v2 2019 |

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| | ○ Pain (p. 53-57, home and community care p.58)<br>○ Polypharmacy (p. 66-71, home and community care p.72)<br>○ Social Engagement (p. 79-82, home and community care p.83) | |
| | • 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.<br>• 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.<br>• 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. | 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 |
| | • Evidence-based approaches to geriatric care (including interdisciplinary comprehensive geriatric assessment, and comprehensive individualized care plans, informed by assessment of geriatric syndromes) improve health | Provincial Findings from MOHLTC Assess and Restore Funded Projects:<br>2014/15 Summary<br>2015/16 Summary |

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| | outcomes, and are associated with improved independence, decreased lengths of stay and decreased rates of re-hospitalization.<br>• 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. | 2016/17 Summary<br>2017/18 Summary<br>2018/19 Summary |
| **Hip fracture** | • All hip fracture patients are to receive an active rehabilitation program following discharge from acute care.<br>• Post-acute rehab is to begin no later than Day six post-surgery and may occur in:<br>o Bedded settings: inpatient rehabilitation and complex continuing care<br>o Community-based settings: rehabilitation in the home or through outpatient physiotherapy clinics<br>o LTC homes in the case of patients admitted from LTC.<br>• 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 pre-fracture | Healthy Quality Ontario (2017) Hip Fracture Quality Standards |

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| | functional status."<br>• 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.<br>• 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 community-based rehabilitative care. | Rehabilitative Care Alliance (2018) Rehabilitative Care Best Practice Guidelines Framework for Patients with for Hip Fracture |
| **Musculoskeletal (MSK)** | • MSK conditions include disorders that affect bones, joints or connective tissue. They include arthritis and related conditions. Physiotherapy within a multidisciplinary program improves physical function, reduces disability and contributes to return to work and other activities.<br>• Physiotherapists have been shown to be knowledgeable and effective in the management of simple to complex MSK conditions and can help reduce demand for appointments with primary care physicians. | Canadian Physiotherapy Association.(2012) The Value of Physiotherapy – Musculoskeletal Conditions.<br><br>Childs, J.D., Whitman, J.M., Sizer, P.S., Pugia, M.L., Flynn, T.W., & Delitto, A. (2005) A description of physical therapists' knowledge in managing musculoskeletal conditions. BMC Musculoskeletal Disorders, 6:32<br><br>Downie, F., McRitchie, C., Monteith, W., & Turner, H. (May 2019) Physiotherapist as an alternative to a GP for musculoskeletal |

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| | | conditions a 2-year service evaluation of UK primary care data. *British Journal of General Practice*, 69(682):e314-e320 |
| **Oncology** | • Rehabilitation, as an essential core component to cancer care, relies on many rehab professions (e.g., physiotherapy, occupational therapy, dietetics, speech and language therapy, podiatry).<br>• 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.<br>• Cognitive rehabilitation and cognitive training is recommended to help patients improve their cognitive skills and find ways to cope with cognitive problems.<br>• Occupational therapy and vocational rehabilitation is recommended to help people with the activities of daily living and job-related skills.<br>• Physiotherapists manage cancer-related fatigue (CRF) by recommending exercise and teaching energy-conservation techniques. They also recommend and/or use exercise with a variety of cancer populations, across all stages of the disease trajectory, in particular during advanced stages of the disease.<br>• Anxiety and depression, fatigue, physical functioning and quality of life have shown improvement in cancer patients who are prescribed and/or participate in various | Rankin, J., Robb, K., Murtagh, N., Cooper, J., & Lewis, S. (Eds.) (2008) *Rehabilitation in cancer care.* Wiley-Blackwell.<br><br>American Society of Clinical Oncology. Attention, Thinking, or Memory Problems. Approved by the Cancer.Net Editorial Board 04/2018<br><br>Donnelly, C.M., Lowe-Strong, A., Rankin, J.P., Campbell, A., Allen, J.M., & Gracey, J.H. (2010) Physiotherapy management of cancer-related fatigue: a survey of UK current practice. *Support Care Cancer.* 18:817–825 https://doi.org/10.1007/s00520-009-0715-2.<br><br>Campbell, K.L., Winters-Stone, K.M., Wiskemann, J., May, A.M., Schwartz, A.L., Courneya, K.S., Zucker, D.S., Matthews, C.E., |

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| | forms of exercise. Kinesiologists use education, intake assessments, exercise-based strategies and other considerations to create an individualized care plan that will assist the patient/client in reaching their health and wellness goals. | Ligibel, J.A., Gerber, L.H., Morris. G.S., Patel, A.V., Hue, T.F., Perna, F.M., & Schmitz, K.H. (2019). Exercise Guidelines for Cancer Survivors: Consensus Statement from International Multidisciplinary Roundtable. *Med Sci Sports Exerc* . Nov; 51(11):2375-2390. DOI: 10.1249/MSS.0000000000002116. |
| **Shoulder arthroplasty** | • A supervised outpatient postoperative physiotherapy program, supplemented by home exercise provided by the hospital at discharge, is recommended for patients who have undergone rotator cuff surgery or shoulder arthroplasty. | Health Quality Ontario (2015). Clinical Handbook for Degenerative Disorders of the Shoulder. |
| | • The optimal location for community rehabilitative care following total and hemi shoulder and reverse arthroplasty is in an outpatient ambulatory setting.<br>• For more information on other considerations, initiation, frequency and duration, see the RCA Best Practice Guidance document on rehabilitative care for patients following shoulder arthroplasty. | 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 |

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| **Stroke** | • People with stroke living in the community who have difficulty with activities of daily living should have access, as appropriate, to therapy services to improve or prevent deterioration in these activities. | Ontario Stroke Evaluation Report 2012 Network: Prescribing System Solutions to Improve Stroke Outcomes |
| | • Physiotherapy, occupational therapy and speech-language therapy be should each be provided three times weekly, for a total of nine visits over seven days per week.<br>• Mild Stroke: Patients with an early AlphaFIM™ score of > 80 would typically go to outpatient rehabilitation or home-based rehabilitation. Age, the availability of a caregiver, the severity of cognitive/perceptual needs, the presence of severe aphasia/dysphagia, and profound inattention/neglect are additional factors that should be taken into consideration. | 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 |
| **Total joint replacement** | • Based on silver-level (level II) evidence, multidisciplinary rehabilitation, following primary hip or knee replacement, can optimize outcomes at the level of activity and participation. Coordinated interprofessional rehabilitative care can be more easily provided in a team-based outpatient setting, than an in-home setting.<br>• For total knee replacement, rehabilitative care should begin within seven days of discharge from acute care.<br>• For total hip replacement, rehabilitative care should begin between two to six weeks from discharge. | Rehabilitative Care Alliance (2019) Rehabilitative Care Best Practice Framework for Patients with Primary Hip and Knee Replacement |

| Conditions typically requiring rehabilitative care | | |
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| **Condition** | **Additional rehabilitative care considerations** | **Source** |
| | • See the complete RCA Guidelines or Quick Reference Guides (Ambulatory) (In-Home) 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. | |
| | • There are numerous individual factors which can impact a patient's rehab trajectory following total joint replacement. Patients who are appropriate for community-based rehabilitation exclude 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. | GTA Rehab Network, (2019) Guideline for Pre-Admission Rehabilitative Care Processes: Primary, elective, unilateral total joint replacement. |