Rehabilitative Care Alliance

# RCA FRAMEWORK FOR BEDDED LEVELS OF REHABILITATIVE CARE

## 1. BACKGROUND AND PURPOSE OF FRAMEWORK

The RCA Framework (formerly Definitions Framework) for Bedded Levels of Rehabilitative Care was originally developed by the RCA's Definitions Task Group. Its mandate was to develop standardized definitions that describe rehabilitative care resources across the continuum.

The RCA Framework for Bedded Levels of Rehabilitative Care is a foundational document that defines (1) the bedded levels of rehabilitative care[i] and (2) the recommended standard components and health human resources within each of these levels of rehabilitative care.

This framework, when first developed in 2014, built on and aligned with functional groups identified by the Provincial Expert Panel's Definitions Working Group and was prepared with input from committee members of the Definitions Task and Advisory Groups, the Frail Seniors/Medically Complex Task and Advisory Groups and the Health Service Providers Advisory Group, each of which included medical, clinical and administrative stakeholders from across organizations and regions. Consultations with rehabilitative care providers across Canada and an extensive review of the literature, including rehabilitation programs/centres in Canada and elsewhere, [1] have also informed the work. Lastly, provincial feedback was sought by way of a validation exercise involving provincial Health Service Provider organizations who were asked to review the RCA Framework for Bedded Levels of Care, determine if their programs offered in rehab, complex continuing care and convalescent care beds (in LTCH) aligned with the levels of rehabilitative care within the framework and provide feedback on the framework and definitions.

The original objectives for developing the RCA bedded framework were to:

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

In FY 2022/2023, the framework was updated to reflect changes in the healthcare environment and provide more clarity in some areas where needed. The work was undertaken under the guidance of the RCA's Rehab Care Standards Task Group.

The updated objectives of the provincial RCA Framework are to describe rehab standards of care for planners and referrers that:

- Are responsive to the increasing complexity of patients
- Are used to inform the establishment of robust and consistent programs across the province
- Support fair and equitable access to rehabilitative care

[i] Bedded levels of rehabilitative care refer to hospital-based designated inpatient rehab beds and complex continuing care beds as well as convalescent care/restorative care beds within LTCH or other location.

Rehabilitative Care Alliance

Note 1: The framework, which is not population-specific, describes the base amount of expected rehab services/resources to meet the needs of most populations. Specialized tertiary services provided by some health service provider organizations may provide additional resources over and above what is described within the framework.

Note 2: The ability to meet these standards of care is dependent on several factors including but not limited to adequate funding, health human resources and staff competency.

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

- Solutions developed by the Rehab Care Standards (Definitions) Task Group will:
  - be developed from the patient's/client's perspective
  - maximize resource utilization
  - standardize and streamline system processes (e.g. eligibility, data collection)

- Definition of rehabilitative care:[2]
  - It is delivered in homes, community-based locations, long term care homes and hospitals.
  - People may require rehabilitative care as a result of illness, injury, lifelong disability, chronic disease, or degenerative condition.
  - It incorporates a broad range of interventions that address one or more of medical/clinical care needs, therapeutic needs, and/or psycho-social needs.
  - The desired outcomes of rehabilitative care will include one or more of maintenance or sustaining of functionality[3], restoration of functionality and/or development of adaptive capacity

- Family/significant others are recognized as key to enabling patient/client function and attainment of goals and are involved throughout the rehabilitative care process:
  - Families/caregivers, with patient/client consent, are included in discussions around key treatment decisions
  - Families (and patients/clients) are encouraged to participate in team meetings
  - Goals and plans are developed from the patient's perspective and in concert with families/caregivers, with patient/client consent

## 2. EXECUTIVE SUMMARY – KEY ELEMENTS OF BEDDED REHABILITATIVE CARE

- The delivery of rehabilitative care is guided by evidence-based best practice and clinical expertise.

- In the levels of care described in this framework, the rehabilitative care focus is on delivering rehabilitation using a coordinated, interprofessional approach to enable individuals with impairments and disabilities to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels.

- Bedded rehabilitative care is categorized into 4 levels of rehabilitative care, which differ in terms of the functional trajectory, goals of rehabilitation, rehab intensity and resources, and patient characteristics. The definitions for the bedded levels of rehabilitative care reflect the understanding that the focus of rehabilitative care across the 4 levels may vary from where it is a primary focus in some levels (e.g. Rehabilitation and Activation/Restoration) to a more secondary focus in others where the medical complexity of the patient is higher than in other levels (e.g. Short and Long Term Complex Medical Management).

| | ***Rehabilitation*** | | ***Activation /Restoration*** | ***Short Term Complex Medical Management*** | ***Long Term Complex Medical Management*** |
|---|---|---|---|---|---|
| | ***High Intensity*** | ***Low Intensity*** | | | |
| **Reporting Bed Type** | NRS | Typically, CCRS | Typically, CCRS-CCC/CCRS-LTC | Typically, CCRS-CCC | Typically, CCRS-CCC |
| **Functional Trajectory** | Progression | Progression | Progression | Stabilization & Progression | Maintenance |
| **Overall goal** | Time-limited rehabilitation, access to a full interprofessional team & coordinated team approach. | | Exercise, functional practice opportunities and recreational activities to increase strength and independence. | Medically complex and specialized services to avoid further loss of function, increase activity tolerance and progress patient | Medically complex and specialized services over an extended period of time to maintain and slow the rate of, or avoid further loss of, function |

- Determination of who would benefit from rehabilitative care and their restorative potential relies on a number of factors that should be considered in tandem to provide a holistic understanding of the patient. These factors include consideration of the following questions:
  - What was the patient's baseline level of functioning?
  - What is the maximum level of functioning that can be expected owing to the patient's medical diagnosis/prognosis and co-morbidities?
  - Is the patient able to engage in rehabilitative care to the extent needed within the context of the patient's specific functional goals and direction of care needs?
  - For patients being considered for short-term complex medical management, is it anticipated that the patient will develop carry-over for learning through the course of treatment even if it is not demonstrated at the time of admission?

  **NB:** Cognitive impairment, depression, delirium or discharge destination should not be used in isolation to influence a determination of a patient's restorative potential.

## 3. ROLE OF REHAB IN ACUTE CARE

Rehabilitative care the acute care setting plays an essential role in optimizing care and outcomes for patients and the health care system. Early intervention in the acute care setting has been shown to reduce hospital-associated deconditioning, reduce the risk of depression and duration of delirium, inform early discharge planning, reduce length of stay and ALC days, and increase the likelihood of discharge to home.[4]

The role of rehab professionals in acute care includes assessing patients' rehabilitative care needs, initiating treatment, preparing patients pre-operatively, providing patient/caregiver education and assisting with transition planning.[5]

Proactive screening in acute care to determine the need for rehabilitation has been shown to be feasible, improve care coordination, patient flow, discharge planning for complex patients, and patient outcomes. Screening domains to proactively identify the rehab needs of patients in acute care include: [6]

- New functional dependency, indicated by an increased level of physical assistance required for mobility, personal care and/or the need for assistive equipment (such as a mobility aid).
- Need for rehab interventions in the acute care setting (such as physiotherapy, occupational therapy, speech-language pathology and other disciplines).
- The presence of pre-existing physical and/or cognitive disabilities.
- 'Medical stability' (no medical interventions requiring acute care in hospital for at least 24 hours prior) and non-medical factors preventing or delaying discharge (such as psychosocial barriers).

Early intervention in the acute care setting has been shown to reduce length of stay, reduce hospital-associated deconditioning and increase the likelihood of discharge to home.[7] For example:

- **Early assessment and intervention by rehabilitative care professionals** serves to identify the patient's baseline status and functional deficits (e.g., physical, cognitive, communication) and psychosocial situation; inform an early discharge planning process; and activate a process for providing support and education to patients and caregivers regarding the patient journey ahead.[8]

- **Early rehabilitative care in acute care can reduce length of stay**. For example, the length of stay for older adults admitted following isolated hip fracture can be reduced by more than 10 days when early rehabilitative care is provided. Reduced length of stay in turn has a positive effect on overall patient flow.[9] From a systems perspective, about 13,000 people living in Ontario experience a hip fracture every year and the health care expenditures associated with hip fracture are substantial, accounting for nearly $500 million of health care spending per year in Ontario.[10]

- **Early rehabilitative care in acute care can increase likelihood of discharge to home.** Rehabilitative care services provided to patients with various conditions (e.g., stroke, spinal cord injury, arthritis, cardiovascular disease, orthopaedic dysfunction, neurological disorders, etc.) who were admitted to acute care result in more discharges to the home environment. From a patient perspective, discharge to home maintains involvement with family and community and supports overall quality of life. From a systems perspective, discharge to home reduces the demand for long-term care home placement.[11]

- **Early mobilization of acute care patients, assessment of functional status and provision of multidisciplinary exercise interventions result in positive patient and system level outcomes.** Functional decline, rapid loss of muscle strength (i.e., up to 5% per week) and reduced ability to ambulate independently are common in older adults who are hospitalized and spend the majority of their days in bed.[12] Reducing the risk of such hospital-acquired functional loss through early mobilization, assessment and a multidisciplinary rehabilitative care has been shown to decrease length of stay, ALC days, risk of depression and the duration of delirium. It also improves patients' functional and cognitive status and increases their rate of discharge to home.[13]

- **Early rehabilitative care involvement pre-operatively and in the acute care phase prepares patients and caregivers** for surgery and the trajectory of functional recovery, the rehabilitation process and the transition to the next phase of the recovery process.[14] [15]

## 4. VIRTUAL CARE

- There has been a move, in part spurred on by the onset of the COVID-19 pandemic, towards offering virtual rehabilitative care following discharge from bedded rehabilitative care.

- Virtual care is defined as "any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies with the aim of facilitating or maximizing the quality and effectiveness of patient care."[16]

- Where possible and if applicable, discussing and planning virtual rehabilitative care with patients before they are discharged from hospital can lead to a smoother transition for the patient to the next phase of their rehabilitation. Not everyone is suitable for virtual rehab and decisions to use it should be made on a case-by-case basis given the goals of rehab, best practice recommendations, the patient's preference and comfort with technology, and the availability of the technology required.[17]

- Meeting with patients and their caregivers (if permitted) on the inpatient unit provides the opportunity to explain what virtual rehab is and how it would be used to provide rehab. The meeting can also explore the feasibility and potential safety risks of providing virtual rehab given the patient's access to technology and assistance in the home. It also allows the space to address patient's questions directly.[18] [19]

Rehabilitative Care Alliance

## 5. CONCEPTUAL FRAMEWORK – BEDDED LEVELS OF REHABILITATIVE CARE

**RCA Framework for Bedded Levels of Rehabilitative Care**

The definitions for the bedded levels of rehabilitative care reflect the understanding that the focus of rehabilitative care across levels of care may vary from where it is a primary focus in some levels (e.g. Rehabilitation – Low and High Intensity and Activation/Restoration) to a more secondary focus in others where the medical complexity of the patient is higher than in other levels (e.g. Short and Long Term Complex Medical Management).

The descriptions of all key components (e.g., Functional Trajectory, Goal, Target Population, Functional Characteristics etc.) within each bedded level of rehabilitative care (e.g., Short Term Complex Medical Management) should be considered in entirety to provide a comprehensive understanding of rehabilitative care provided in that level of care.

Note: The framework is not intended to be inclusive of all beds within CCC or Acute Care where rehabilitative care is not the primary purpose/focus of care (i.e. Palliative Care, Respite, Behavioural programs as well as programs where patients are waiting for an alternate level of care). However, there is recognition that patients within these programs may receive some rehabilitative care for maintenance during their admission.

**THE REHABILITATION ENVIRONMENT IS ONE THAT IS ACTIVE AND STIMULATING THROUGHOUT THE DAY. ACTIVITIES BETWEEN CORE SESSIONS MAY INCLUDE GROUP THERAPY, EDUCATIONAL SESSIONS WITH PATIENTS AND FAMILIES FOR SELF-MANAGEMENT STRATEGIES, ACTIVITIES WITH THERAPY ASSISTANTS, NURSES AND OTHERS.**

| *Level of Rehabilitative Care* | *Rehabilitation* | | *Activation /Restoration* | *Short Term Complex Medical Management* | *Long Term Complex Medical Management* |
|---|---|---|---|---|---|
| | *High Intensity* | *Low Intensity* | | | |
| ***Reporting Bed Type*** | NRS | Typically, CCRS | Typically, CCRS-CCC/CCRS-LTC | Typically, CCRS-CCC | Typically, CCRS-CCC |
| ***Functional Trajectory*** | Progression | Progression | Progression | Stabilization & Progression | Maintenance |
| ***Goal*** | | | | | |
| ***Target Population*** | | | | | |
| ***Patient Functional Characteristics*** | | | | | |
| ***Estimated LOS*** | | | | | |
| ***Discharge Indicator*** | | | | | |
| ***Medical Care*** | | | | | |
| ***Nursing Care*** | | | | | |
| ***Health Professionals*** | | | | | |
| ***Amount of Therapy*** | | | | | |

## 6. ELIGIIBILITY CRITERIA FOR BEDDED REHABILITATIVE CARE

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

- The patient has restorative potential*, (i.e. there is reason to believe, based on clinical assessment and expertise and evidence in the literature where available, that the patient's/client's condition is likely to undergo functional improvement and benefit from rehabilitative care);

  Note: While some patients being considered for Long Term Complex Medical Management may not be expected to undergo functional improvement, the restorative potential of patients can be considered from their ability to benefit from rehabilitative care (i.e. maintaining, slowing the rate of or avoiding further loss of function).

  *and*

- The patient is medically manageable such that the patient can be safely managed with the resources that are available within the level of rehabilitative care being considered. There is a clear diagnosis for acute issues; co-morbidities have been established; there are no undetermined acute medical issues (e.g. excessive shortness of breath, congestive heart failure); vital signs are stable; medication needs have been determined; and there is an established plan of care. However, some patients (particularly those in the Short and Long Term Complex Medical Management levels of rehabilitative care) may experience temporary fluctuations in their medical status, which may require changes to the plan of care;

  *and*

- The patient/client has identified goals that are specific, measurable, realistic and timely;

  *and*

- The patient/client is able to actively participate in and benefit from rehabilitative care within the context of the patient's specific functional goals (See note);

  Note: Patients being considered for short term complex medical management may have limited physical and/or cognitive capacity to engage in a rehabilitative care program due to medical complexity; however, it is believed that the patient has restorative potential and that this level of care will provide the opportunity to optimize restorative potential where possible and assess the patient's rehabilitative care needs following further stabilization of medical condition;

  *and*

- The patient's/client's goals/care needs cannot otherwise be met in the community.

*Restorative Potential

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

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

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

## 7. RCA FRAMEWORK FOR BEDDED LEVELS OF REHABILITATIVE CARE

**RCA Framework for Bedded Levels of Rehabilitative Care**

This framework refers to inpatient rehab beds (i.e., NRS reporting bed) and complex continuing care beds (CCRS-CCC reporting beds) as well as convalescent care beds within LTCH. The definitions for the bedded levels of rehabilitative care reflect the understanding that the focus of rehabilitative care across levels of care may vary from where it is a primary focus in some levels (e.g. Rehabilitation – Low and High Intensity and Activation/Restoration) to a more secondary focus in others where the medical complexity of the patient is higher than in other levels (e.g. Short and Long Term Complex Medical Management).

The descriptions of all key components (e.g., Functional Trajectory, Goal, Target Population, Functional Characteristics etc.) within each bedded level of rehabilitative care (e.g., Short Term Complex Medical Management) should be considered in entirety to provide a comprehensive understanding of rehabilitative care provided in that level of care.

Note: The framework is not intended to be inclusive of all beds within CCC or Acute Care where rehabilitative care is not the primary purpose/focus of care (i.e. Palliative Care, Respite, Behavioural programs as well as programs where patients are waiting for an alternate level of care). However, there is recognition that patients within these programs may receive some rehabilitative care for maintenance during their admission.

**THE REHABILITATION ENVIRONMENT IS ONE THAT IS ACTIVE AND STIMULATING THROUGHOUT THE DAY. ACTIVITIES BETWEEN CORE SESSIONS MAY INCLUDE GROUP THERAPY, EDUCATIONAL SESSIONS WITH PATIENTS AND FAMILIES FOR SELF-MANAGEMENT STRATEGIES, ACTIVITIES WITH THERAPY ASSISTANTS, NURSES AND OTHERS.**

| ***Level of Care*** | ***Rehabilitation*** | | ***Activation / Restoration*** | ***Complex Medical Management - Short Term*** | ***Complex Medical Management - Long Term*** |
|---|---|---|---|---|---|
| | ***High intensity*** | ***Low intensity*** | | | |
| ***Reporting Bed Type*** | *NRS* | *Typically, CCRS* | *Typically, CCRS-CCC/CCRS-LTC* | *Typically, CCRS-CCC Reporting* | *Typically, CCRS-CCC* |
| ***Functional Trajectory*** | Progression | Progression | Progression | Stabilization & Progression | Maintenance |
| ***Goal*** | • Rehabilitation is focused on enabling, individuals with impairments and disabilities to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. [20] | | • To ***promote activity, increase strength, endurance, independence and ability to manage activities of daily living*** by providing access to therapies with a focus on restoring function. These include functional practice opportunities, wellness and self-care activities that support the return of patients to their previous living | • To provide medically complex and specialized services ***to avoid further loss of function, increase activity tolerance and progress patient*** so that the patient may be able to go home OR may be able to be discharged to another level of | • To provide medically complex and specialized services over an extended period of time ***to maintain, slow the rate of or avoid further loss of function*** where "in the opinion of the attending physician, the patient requires chronic/complex |

| *Level of Care* | *Rehabilitation* | | *Activation / Restoration* | *Complex Medical Management - Short Term* | *Complex Medical Management - Long Term* |
|---|---|---|---|---|---|
| | *High intensity* | *Low intensity* | | | |
| | • *To develop and provide **a time limited coordinated, interprofessional high intensity rehabilitation plan of care through a combined and coordinated use of medical, nursing and allied health professional skills**.*[24] | • *To develop and provide **a time limited coordinated, interprofessional low intensity rehabilitation plan of care through a combined and coordinated use of medical, nursing and allied health professional skills**.*[25] | environment or other appropriate community environment.<br>Note: For patients accessing bedded levels for Activation/Restoration, the anticipated discharge destination cannot be a Long-Term Care Home (LTCH) as patients cannot wait in the Activation/Restoration bed for a LTCH bed. | (rehabilitative) care wherever possible.[21 22] | continuing care and is, and will continue to be more or less a permanent resident in the hospital". [23] |
| ***Target Population*** | Patients who:<br>• Have experienced sudden onset, life-altering disability (e.g. SCI, ABI, stroke, amputation, multiple traumas) with an expected trajectory of recovery/progression should be considered.<br>• May be at high risk of permanent loss of living independently in the community. | | Patients who:<br>• Are medically stable and physically and cognitively able to participate in restorative activities (e.g., patients are assisted with walking and self-care and participate in individual and/or group exercise programs, recreational activities and group dining) designed to enable patients to return home by increasing their strength, endurance and ability to manage activities of daily living following an acute care hospital stay or admission from the community.<br>• May require access to a physician on a 24/7 on-call basis<br>• Patients are expected to have a discharge location, typically home. Some patients could be preparing for active rehabilitation before returning home.[26] | Patients who:<br>• On admission, typically have limited physical and/or cognitive capacity to engage in a rehabilitative care program due to medical complexity.<br>• However, it is believed that the patient has restorative potential and that this level of care will provide the opportunity to optimize restorative potential where possible and assess the patient's rehabilitative care needs following further stabilization of medical condition<br>• May require access to a physician on a 24/7 on-call basis | Patients who:<br>• Are medically complex, with longer-term illnesses or disabilities typically requiring:<br>○ Ongoing medical / nursing support;<br>○ Skilled, technology-based care not available at home or in long-term care facilities.[27]<br>○ Assessment and active care management by specialized interprofessional teams.[28 29]<br>• May require access to a physician on a 24/7 on-call basis |
| | Patients who:<br>• Are medically stable with significant functional impairments and who require and are able to participate in a comprehensive interprofessional rehabilitation program at **a high intensity** to enhance functional and cognitive ability.<br>• May require access to a physician on a 24/7 on-call basis | Patients who:<br>• Are medically stable with significant functional impairments and who require and are able to participate in a comprehensive interprofessional rehabilitation program at **a low intensity** to enhance functional and cognitive ability.<br>• May require access to a physician on a 24/7 on-call basis | | | |

<table>
<tr><th rowspan="2">Level of Care</th><th colspan="2">Rehabilitation</th><th rowspan="2">Activation / Restoration</th><th rowspan="2">Complex Medical Management - Short Term</th><th rowspan="2">Complex Medical Management - Long Term</th></tr>
<tr><th>High intensity</th><th>Low intensity</th></tr>
<tr><td>Patient Functional Characteristics</td><td colspan="3">Patients:<ul><li>Are medically stable such that there is a clear acute diagnosis; co-morbidities have been established; there are no undetermined medical issues (e.g. excessive shortness of breath, congestive heart failure); vital signs are stable; medication needs have been determined; and there is an established medical plan of care;</li><li>Have identified goals for rehabilitation that are specific, measurable, attainable, realistic, and time-limited, which cannot otherwise be met in the community.</li><li>Have no behavioural or mental health issues, which cannot be mitigated through the use of strategies, resources and/or environmental modifications, and which limit the patient’s ability to participate.</li></ul></td><td colspan="2">Patients:<ul><li>Are medically stable (although the patient may be at risk for an acute exacerbation) such that there is a clear diagnosis/prognosis; co-morbidities have been established; there are no undetermined acute medical issues (e.g. excessive shortness of breath, congestive heart failure); vital signs are stable;</li><li>Medication needs have been determined; and there is an established plan of care; however, some patients may experience temporary fluctuations in their medical status, which may require changes to medications/plan of care.</li></ul></td></tr>
<tr><td><ul><li>Achievement of goals requires daily interventions, frequent/daily re-assessment by regulated health professionals to update and progress the treatment plan, and a coordinated team approach by a dedicated/in-house interprofessional team of regulated health professionals.</li><li>Although the patient’s initial functional tolerance may fluctuate, the patient has the cognitive ability and the physical tolerance to participate in and progress through daily high intensity rehabilitation (as further described in the Health Professionals & Amount of Therapy sections)</li><li>Patients are expected to return to their previous living environment or other appropriate community environment following participation in rehabilitation.</li></ul></td><td><ul><li>Achievement of goals requires a coordinated team approach by a dedicated/in-house interprofessional team of regulated health professionals with frequent re-assessment by regulated health professionals to update and progress the treatment plan</li><li>Although the patient’s initial functional tolerance may fluctuate, the patient has the cognitive ability and the physical tolerance to participate in and progress through low intensity rehabilitation 3-5 days per week (as further described in the Health Professionals & Amount of Therapy sections)</li><li>Patients are expected to return to their previous living environment or other appropriate community environment following participation in rehabilitation.</li></ul></td><td><ul><li>Achievement of goals does not require daily access to a comprehensive, interprofessional rehabilitation team using a coordinated team approach. Goals are primarily addressed through exercise and recreational activities.</li><li>Although the patient’s functional tolerance may fluctuate, the patient has the cognitive ability and physical tolerance to participate in restorative activities provided at an intensity available at this level of care (as described in the Health Professionals & Amount of Therapy section).</li><li>Patients are expected to have a discharge location, typically home. Some patients could be preparing for active rehabilitation before returning home.[30]</li></ul></td><td>Patients:<ul><li>Require skilled nursing and medical care that cannot be met on an ongoing basis in other levels of rehabilitative care</li><li>For whom it is anticipated as their medical condition and tolerance improves that they will be able to engage in limited rehabilitative activities (e.g. regain sitting balance, improve upper/lower extremity strength and coordination, increase transfers and functional mobility, assess and train patient/caregiver on optimal positioning, learning how to sequence activities through functional tasks, self-care with assistance, being up/walking for short periods)</li></ul></td><td>Patients:<ul><li>Require skilled nursing and medical care that cannot be met on an ongoing basis in LTC or other community setting</li><li>For whom it is anticipated, due to limited physical and/or cognitive capacity, that the degree of additional functional gain will be low</li></ul></td></tr>
<tr><td>Estimated LOS</td><td colspan="5">The rehabilitative care team in the bedded program will inform patients after admission and the initial assessment about the anticipated length of stay of the specific program to which the patient has been admitted.</td></tr>
</table>

| *Level of Care* | *Rehabilitation* | | *Activation / Restoration* | *Complex Medical Management - Short Term* | *Complex Medical Management - Long Term* |
|---|---|---|---|---|---|
| | *High intensity* | *Low intensity* | | | |
| | • Consider best practice targets where available based on RPGs and/or clinical assessment and rehab goals<br>• To be considered in conjunction with the Discharge Indicator section below<br>• Typically, a range of 7 – 40 days | • Consider best practice targets where available based on RPGs and/or clinical assessment and rehab goals<br>• To be considered in conjunction with the Discharge Indicator section below<br>• Typically, a range of 30 – 60 days | • Up to 90 days | • Up to 90 days | • Will remain in this level because the patient's functional status/medical care needs cannot otherwise be met in the community. |
| ***Discharge Indicator*** | • No longer requires ongoing nursing care and on-site access to MD.<br>• Identified rehab goals for bedded level of rehabilitative care have been met and additional progress can be achieved independently or with the assistance of a caregiver at home or through community-based rehabilitation[31] | | • No longer requires ongoing nursing care and on-site access to MD.<br>• Identified rehab goals for bedded level of rehabilitative care have been met and additional progress can be achieved independently or with the assistance of a caregiver at home or through community-based rehabilitation[32] | • Medical/functional recovery so as to allow patient to safely transition to the next level of rehabilitative care or an alternative level of care environment.<br>• Patients who are unable to transition to another level of care and require ongoing care will be considered for transition to a long-stay level of care. | • The patient is designated to be more or less a permanent resident in the hospital and will remain until the medical/functional status changes so as to allow the patient to safely transition to another level of care or to the community. |
| | A small proportion of these patients may require discharge to an alternate care facility if:[33]<br>• The patient requires a residential setting with 24-hour support and/or access to on-site nursing care and/or on-site access to MD for monitoring<br>• Identified goals for bedded level of rehabilitative care have been met or the patient's functional status has reached a plateau and the patient is not demonstrating any significant progress towards making further gains but may have the potential to make minimal gains over time which could be achieved in an alternate level of care *and*<br>• None of the publicly-funded community services and caregiving, support or companionship arrangements in the patient's home can meet the patient's functional and care needs. | | | | |
| | **Note**: At each transition point, mechanisms for the coordination and communication of the post-discharge rehabilitative care plan with the receiving provider(s) and patient and families/caregivers should be in place to support a successful transition. [34] | | | | |
| ***Medical Care*** | Physician assessment on admission<br>24/7 on-call physician | | | | |
| | • Access to daily physician or applicable alternate designate assessment is available if needed | • Access to daily physician or applicable alternate designate assessment is available if needed | • Access to weekly physician follow-up/oversight | • Access to scheduled physician care/daily medical oversight as clinically necessary | • Access to weekly physician follow-up/oversight<br>• Up to 8 monitoring visits per month[35] |

| *Level of Care* | *Rehabilitation* | | *Activation / Restoration* | *Complex Medical Management - Short Term* | *Complex Medical Management - Long Term* |
|---|---|---|---|---|---|
| | *High intensity* | *Low intensity* | | | |
| ***Interprofessional Rehab Team*** | Members of the interprofessional rehab team (see Health Professionals section below), as a result of their training, have developed a specialized skill set to develop and implement comprehensive, goal-directed plans with patients and families that assess function and what individuals require to return to the community or transition to the next level of care. Rehab plans address all aspects of a person's needs, including their physical, cognitive and psychosocial needs. Rehab nursing enables patients and families to adapt to illness and injury and uses therapeutic communication and integration of therapeutic skills in activities of daily living as a way to make a difference to rehabilitation outcomes. Activities of the team include but are not limited to: assessment, providing rehab treatment, discharge planning, education and counselling, collaborating with other members of the team, and preparing clinical documentation.<br>For more information about rehab professionals and their areas of expertise, see Section 3: About Rehab Professionals of the RCA's primer in the RCA's Patient and System-Level Benefits of Rehabilitative Care: A primer to support planning by OHTs and Ontario Health (2020) | | | | |
| ***Nursing Care*** | • Patient typically requires up to 3 hours nursing care per day; however, some patients may require up to 4 hours per day | • Patient typically requires up to 3 hours nursing care per day; however, some patients may require up to 4 hours per day | • Patient typically requires nursing care ≤ 2 hours/day. | • Patient typically requires nursing care > 3 hours/day; | • Requires nursing care > 3 hours/day |
| ***Health Professionals*** | • Direct daily therapy on **5-7 days per week** (in alignment with treatment plan and patient tolerance) is provided by regulated health professionals within a dedicated, interprofessional team model of care with expertise in rehabilitation populations.<br>• The interprofessional team should have the expertise and skills to assess and treat a variety of conditions (e.g., brain injury, neurological conditions, older adults with frailty, orthopedics, spinal cord injury, stroke).<br>• The interprofessional team should include but may not be limited to: Clinical dietitian, discharge planner (as filled by: social worker, discharge planner/coordinator, patient flow coordinator, etc.), nurse, occupational therapist, pharmacist, physiotherapist, physiatrist and/or geriatrician, social worker, speech-language pathologist.<br>• Ideally, consultation is available from all of the following professionals: Chaplain/pastoral care provider, | • Direct therapy on **3-5 days per week** (in alignment with treatment plan and patient tolerance) is provided by regulated health professionals within a dedicated, interprofessional team model of care with expertise in rehabilitation populations.<br>• The interprofessional team should have the expertise and skills to assess and treat a variety of conditions (e.g., brain injury, neurological conditions, older adults with frailty, spinal cord injury, stroke).<br>• The interprofessional team should include but may not be limited to: Clinical dietitian, discharge planner (as filled by: social worker, discharge planner/coordinator, patient flow coordinator, etc.), nurse, occupational therapist, pharmacist, physiotherapist, physiatrist and/or geriatrician, | • The rehabilitative plan of care is delivered largely by non-regulated health professionals, who may or may not be under the direction/supervision of a regulated health professional[38] to provide programming for restoration/activation (e.g. patients are assisted with walking, self care and participate in individual and/or group exercise programs, recreational activities and group dining)<br>• On-site therapy resources are limited to:<br>○ Physiotherapy (limited to providing an exercise program of 15 min/day on a 1:1 basis)<br>○ Non-regulated Activation / Recreational staff<br>○ Nursing<br>○ Social worker<br>○ Dietitian<br>○ Occupational Therapy and Speech Language Therapy may be available on a consultation basis. | • Regulated health professionals available to maintain and maximize cognitive, physical, emotional and functional abilities through limited rehabilitative activities (e.g. regain sitting balance, improve upper extremity strength and coordination, increase transfers and functional mobility, assess and train patient/caregiver on optimal positioning, learning how to sequence activities through functional tasks, self-care with assistance, being up/walking for short periods) | • Regulated health professionals are available to maintain and optimize cognitive, physical, emotional and functional abilities |

| *Level of Care* | *Rehabilitation* | | *Activation / Restoration* | *Complex Medical Management - Short Term* | *Complex Medical Management - Long Term* |
|---|---|---|---|---|---|
| | *High intensity* | *Low intensity* | | | |
| | chiropodist, psychiatrist and/or geriatric psychiatrist, psychologist and/or neuropsychologist, behavioural therapist, recreation therapist, neurologist, and wound care specialist. Consultation may also be available from audiology.<br>• This care is evidenced by the establishment of achievable treatment goals, the daily/frequent assessment and documentation of the functional status of patients and the occurrence of regular case discussion amongst treating practitioners.[36] | social worker, speech-language pathologist.<br>• Ideally, consultation is available from all of the following professionals: Chaplain/pastoral care provider, chiropodist, psychiatrist and/or geriatric psychiatrist, psychologist and/or neuropsychologist, behavioural therapist, recreation therapist, neurologist and wound care specialist. Consultation may also be available from audiology.<br>• This care is evidenced by the establishment of achievable treatment goals, the daily/frequent assessment and documentation of the functional status of patients and the occurrence of regular case discussion amongst treating practitioners.[37] | | | |
| ***Amount of Therapy*** | The rehabilitation environment is one that is active and stimulating throughout the day. Activities between core sessions may include group therapy, educational sessions with patients and families re: self-management strategies, activities with therapy assistants, nurses and others.[39] | | | | |
| | The minutes below reflect the amount of time spent with the patient or family to provide direct assessment and/or therapy per day by the following core therapies: Occupational Therapy, Physiotherapy and Speech-Language Pathology, some of which may be provided by a therapy assistant under the direction and supervision of the associated regulated health professional.<br>Note: The role of the interprofessional team and a listing of other team members is provided above in the Medical Care, Interprofessional Rehab Team, Nursing Care and Health Professionals sections. | | | | |
| | **HI Low End** | **HI Medium End** | **HI High End** | **LI Low End** | **LI High End** | **Activation/Restoration** | **CMM Rehab-Short Term** | **CMM Rehab-Long Term** |
| ***Total minutes of direct assessment and/or therapy per day*** | 60 minutes | 90 – 120 minutes | 180 minutes | 30 minutes | 30 – 60 minutes | 15 – 30 minutes | 15 -30 minutes | Regulated health professionals are available to maintain and optimize cognitive, physical, |

| *Level of Care* | *Rehabilitation* | | | | | *Activation / Restoration* | *Complex Medical Management - Short Term* | *Complex Medical Management - Long Term* |
|---|---|---|---|---|---|---|---|---|
| | *High intensity* | | | *Low intensity* | | | | |
| ***# Days / week patient is able to participate*** | 5 days | 5 days | 5 – 7 days | 3-5 days | 5 days | 3-5 days | 3 -5 days | emotional and functional abilities |
| | **Rehab therapists engage in the following activities*:**<br>• Assessment: screening, physical health assessment, cognitive assessment, psycho-social assessment, functional assessment, diagnostic procedures, clinical documentation<br>• Therapeutic Intervention: treatment procedures; locate/arrange resources/support activities; patient transportation; monitoring/evaluation/counseling/patient teaching; planning; clinical documentation<br>• Consultation/Collaboration: Case conference; team meeting; team rounds; reports; clinical documentation. (Note: These are not included in the total minutes of direct assessment and/or therapy per day noted above, but are included within the definition of Service Recipient activities in CIHI's Management Information Systems standards.)<br><br>*These Service Recipient activities are defined by the Canadian Institute for Health Information in its Standards for Management Information Systems in Canadian Health Service Organizations. https://www.cihi.ca/en/submit-data-and-view-standards/data-standards/management-information-system-standards. The data collected in the Management Information System (MIS) is used to understand resource use and inform resource allocations and budget development. | | | | | | | |

Rehabilitative Care Alliance

# Endnotes

[1] See Definitions Task Group Backgrounder Document, October 2013. https://rehabcarealliance.ca/wp-content/uploads/2022/10/Definitions_Task_Group_BackgrounderFINAL.pdf
[2] Rehabilitative Care Conceptual Framework. Developed by Definitions Working Group for the Rehabilitation and Complex Continuing Care Expert Panel. Nov 2011.
[3] The concept of functionality is derived from the WHO/World Bank "World Report on Disability, 2011" which describes functioning as: "An umbrella term in the ICF for body functions, body structures, activities, and participation. It denotes the positive aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors). See World report on disability 2011. World Health Organization. https://apps.who.int/iris/handle/10665/44575
[4] Rehabilitative Care Alliance (Nov 2020) Patient and System-Level Benefits of Rehabilitative Care: A primer to support planning by OHTs and Ontario Health
[5] Rehabilitative Care Alliance. (Nov 2020) Patient and System-Level Benefits of Rehabilitative Care: A primer to support planning by OHTs and Ontario Health
[6] Wu J., Misa, O., Shiner, C.T., & Faux, S.G. (2021) Targeted rehabilitation may improve patient flow and outcomes: development and implementation of a novel Proactive Rehabilitation Screening (PReS) service. *BMJ* Open Quality. 10:e001267. doi:10.1136. bmjoq-2020-001267
[7] Rehabilitative Care Alliance. (Nov 2020) Patient and System-Level Benefits of Rehabilitative Care: A primer to support planning by OHTs and Ontario Health
[8] Heart and Stroke Foundation Canada. (2019). Canadian stroke best practice recommendations – Stroke rehabilitation. 6th edition, 2019 update. Retrieved from https://www.strokebestpractices.ca/recommendations/stroke-rehabilitation/delivery-of-inpatient-stroke-rehabilitation
[9] Kimmel, L. A., Liew, S. M., Sayer, J. M. & Holland, A. E. (2016). HIP4Hips (High intensity physiotherapy for hip fractures in the acute hospital setting): A randomised controlled trial. *Medical Journal of Australia*. 205(2), 73-78.) https://onlinelibrary.wiley.com/doi/epdf/10.5694/mja16.00091
[10] Healthy Quality Ontario (2017). Hip Fracture Quality Standards. Retrieved from https://www.hqontario.ca/portals/0/documents/evidence/quality-standards/qs-hip-fracture-clinical-guide-en.pdf
[11] Ostrow, P., Parente, R., Ottenbacher, K. & Bonder, B. (1989). Functional outcomes and rehabilitation: An acute care field study. *Journal of Rehabilitation Research and Development*, 26(3), 17-26.
[12] Liu, B., Almaawy, U., Moore, J.E., Chan, W.H., Straus, S.E., & MOVE ON Team. (2013). Evaluation of a multisite educational intervention to improve mobilization of older patients in hospital: protocol for mobilization of vulnerable elders in Ontario (MOVE ON). *Implementation Science*, 8:76 https://doi.org/10.1186/1748-5908-8-76.
[13] Liu, B., Almaawy, U., Moore, J.E., Chan, W.H., Straus, S.E., & MOVE ON Team. (2013). Evaluation of a multisite educational intervention to improve mobilization of older patients in hospital: protocol for mobilization of vulnerable elders in Ontario (MOVE ON). *Implementation Science*, 8:76 https://doi.org/10.1186/1748-5908-8-76.
[14] Smith, S., Pursey, H., Jones, A., Baker, H., Springate, G., Randell, T., Moloney, C., Hancock, A., Newcombe, L., Shaw, C., Rose, A., Slack, H., & Norman, C. (2016). Clinical guidelines for the pre and post-operative physiotherapy management of adults with lower limb amputations'. 2nd Edition.
[15] Rehabilitative Care Alliance. (2019). Total Joint Replacement Framework. Retrieved from https://www.rehabcarealliance.ca/wp-content/uploads/2022/10/TJR_Framework.pdf
[16] Ontario Health. (2020) Recommendations for Regional Health Care Delivery during the COVID-19 Pandemic: Outpatient Care, Primary Care, and Home and Community Care.
[17] Rakover, J., Laderman, M., & Anderson, A. (Sept/Oct 2020). Telemedicine: Centre Quality and Safety. *Healthcare Executive.* Sept:35(5):48-49.
[18] Ontario Health. (2020) Recommendations for Regional Health Care Delivery during the COVID-19 Pandemic: Outpatient Care, Primary Care, and Home and Community Care.
[19] Boissy et al. (2016) Conditions of Use, Reliability, and Quality of Audio/Video-Meditated Communications during In-Home Rehabilitation Teletreatment for Postknee Arthroplasty. Telemedicine and e-Health. 22(8) DOI: 10.1089/tmj.2015.0157. https://pubmed.ncbi.nlm.nih.gov/26958932/
[20] World Health Organization. https://www.who.int/news-room/fact-sheets/detail/rehabilitation
[21] Sinha, Samir K. Living Longer, Living Well. December 2012. https://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors_strategy/docs/seniors_strategy_report.pdf
[22] Ministry of Health and Long-Term Care (2014). Assess and Restore Guideline https://www.health.gov.on.ca/en/pro/programs/assessrestore/docs/ar_guideline.pdf
[23] MOHLTC, Hospital Complex Continuing Care (CCC) Co-payment, Questions and Answers, Resource to LHINs and Hospitals, Updated May 2010.
[24] Australian Faculty of Rehabilitation Medicine (2011). Standards for the Provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals.
[25] Australian Faculty of Rehabilitation Medicine (2011). Standards for the Provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals.
[26] Admission to Long-Term Care Homes, Community Care Access Centres Client Services Policy Manual. https://silo.tips/download/community-care-access-centres-client-services-policy-manual
[27] Ontario Ministry of Health and Long Term Care. Complex Continuing Care Co-payment 2010.
[28] MOHLTC, Hospital Complex Continuing Care (CCC) Co-payment, Questions and Answers, Resource to LHINS and Hospitals, Updated May 2010.

[29] Ontario Hospital Association. Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System. May 2006.
[30] Admission to Long-Term Care Homes, Community Care Access Centres Client Services Policy Manual. https://silo.tips/download/community-care-access-centres-client-services-policy-manual
[31] GTA Rehab Network, Discharge Planning Guidelines for Inpatient Rehabilitation. 2009. https://gtarehabnetwork.ca/wp-content/uploads/2022/08/discharge-planning-guidelines.pdf
[32] GTA Rehab Network, Discharge Planning Guidelines for Inpatient Rehabilitation. 2009. https://gtarehabnetwork.ca/wp-content/uploads/2022/08/discharge-planning-guidelines.pdf
[33] GTA Rehab Network, Discharge Planning Guidelines for Inpatient Rehabilitation. 2009. https://gtarehabnetwork.ca/wp-content/uploads/2022/08/discharge-planning-guidelines.pdf
[34] Health Quality Ontario. Adopting a Common Approach to Transitional Care Planning: Helping Health Links Improve Transitions and Coordination of Care. Retrieved from http://www.hqontario.ca/Portals/0/documents/qi/health-links/bp-improve-package-traditional-care-planning-en.pdf
[35] MOHLTC, Hospital Complex Continuing Care (CCC) Co-payment, Questions and Answers, Resource to LHINS and Hospitals, Updated May 2010.
[36] Australian Faculty of Rehabilitation Medicine (2011). Standards for the Provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals.
[37] Australian Faculty of Rehabilitation Medicine (2011). Standards for the Provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals.
[38]Under the convalescent care program, there is access to a core interprofessional team of "qualified practitioners including medicine, nursing, physiotherapy, recreation therapy, occupational therapy, dietetics, social work and personal support". MOHLTC, Long-Term Care Home Policy, July 2010 http://www.health.gov.on.ca/en/public/programs/ltc/docs/short_stay_beds_policy.pdf
[39] See https://www.corhealthontario.ca/Ontario-Regional-Stroke-Networks-Stroke-Rehabilitation-Intensity-FAQs.pdf and https://www.corhealthontario.ca/CorHealth-Ontario-Stroke-Rehabilitation-Intensity-Backgrounder.pdf