RCA Framework for Community-Based Levels of Rehabilitative Care

1. BACKGROUND AND PURPOSE OF FRAMEWORK

The RCA Framework (formerly Definitions Framework) for Community-Based 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. This framework, along with the RCA Framework for Bedded Levels of Rehabilitative Care, serve as foundational documents that define:

1. the levels of rehabilitative care across the continuum
2. the recommended standard components and human resources within each level of rehabilitative care.

While there is recognition that the framework is not population-specific and that the specialized tertiary services provided by some Health Service Provider organizations are beyond the resource thresholds described within the framework, the framework can be used by regions as part of a capacity planning process to evaluate rehabilitative care resources within the context of specific patient/client and local/regional programming needs.

The original framework was developed in 2015 with input from committee members of the Definitions Task and Advisory Groups and regional leads[*], each of which included medical, clinical and administrative individuals from across organizations. The framework was also informed by consultations with rehabilitative care providers across the province and nationally as well as an extensive review of the literature regarding rehabilitation programs/centres in Canada and elsewhere.[1]

In 2023/2024, the framework was updated to incorporate the most recent literature reviews and consultations with rehab partners that was undertaken by the RCA's Community-Based Rehab Task Group. The revised framework was reviewed and finalized by the RCA Rehab Care Standards Task Group.

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

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

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

***Note:** While wellness focused health promotion/prevention programs that are not provided by or supervised under regulated health professionals are beyond the scope of the RCA Framework for Community-Based Levels of Rehabilitative Care, it is acknowledged that such programs play an important role in the system by promoting overall health and supporting patients'/client's

[*] the LHIN Leads/Health Service Providers Advisory Group

reintegration into the community. Such programs may be integrated into the services provided by regulated health care professionals. Examples of these programs include: group exercise; wellness promotion classes; swimming; walk-fit; yoga; Tai-Chi; Pilates; peer support and friendly visiting programs.

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/caregivers[†] 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
  - Families/caregivers work collaboratively with the care team to achieve treatment goals and support the implementation of therapy at home
- Goals and plans are developed from the patient's/client's perspective and in concert with families/caregivers, with patient/client consent.

[†] Note: caregiver" refers to family members, friends, or supportive people not necessarily related to the patient/client

2. EXECUTIVE SUMMARY – KEY ELEMENTS OF COMMUNITY-BASED REHABILITATIVE CARE

- This framework refers to community-based rehabilitative care that is provided by or under the supervision of regulated health professionals who have the knowledge, skills and expertise in rehabilitative care. The framework is not specific to any population; it serves as a baseline framework to describe the goals of therapy, patient/client characteristics and therapy resources/services in each level of rehabilitative care.
- The framework is divided into two sections. Step 1 of the framework provides information for determining which level of community-based rehabilitative care would meet the needs of the patient/client based on the functional trajectory of treatment (i.e., progression vs. maintenance). Step 2 of the framework provides a referral decision tool for determining the location of community-based rehabilitative care.
- While the framework refers only to services provided by or under the supervision of regulated health professionals (e.g., rehabilitation assistants and communication disorder assistants), it is recognized that other non-regulated providers (e.g., recreation therapists) are important members of rehabilitation teams and services. [4] Wellness focused health promotion/prevention programs that are provided by non-regulated individuals play an important role in the system by promoting overall health and supporting patients'/client's reintegration into the community. These programs should be considered by providers within the defined levels of rehabilitative care when discharge planning and transitioning patients/clients to self-management activities. Examples of these programs include: group exercise; wellness promotion classes; swimming; walk-fit; yoga; Tai-Chi; Pilates; peer support and friendly visiting programs.
- Community-based rehabilitative care results in both patient/client and system-level outcomes. [5] From a systems perspective, improving access to community-based rehabilitative care services (including virtual care options) will reduce wait times, avoid emergency department use, reduce inpatient admissions and support earlier inpatient discharge with reduced lengths of stay. [6] From a patient/client perspective, by offering a broad range of interventions, community rehabilitation can help prevent disease or injury from occurring or re-occurring (primary and secondary prevention), help restore and maximize functional abilities, help patients/clients adjust to new functional levels or complex conditions, adapt their skills and reintegrate into the community. [7]
- Community-based rehabilitation can be categorized into three patient/client-centred, needs-based categories: Primary Prevention, Post-Injury/Illness and Progressive/Chronic Conditions. Patients/clients may fall under more than one category. Where more than one service is required, rehabilitative care should be provided using an interprofessional, integrated and coordinated team approach. [8]

3. ROLE OF COMMUNITY-BASED REHABILITATIVE CARE

Community-based rehabilitation (in-home and outpatient / clinic settings) is focused on enabling individuals with impairments and disabilities to reach and maintain their optimal physical, sensory, intellectual, communicative, psychological, leisure, and social functional levels. Rehabilitation offers a broad range of interventions to promote health and well-being, re-integration to and participation in community living and to optimize quality of life following illness and injury for people across all age ranges. Community-based rehabilitative care also plays a key role in primary and secondary prevention to prevent disease or injury from occurring or re-occurring. [9]

Rehabilitation professionals develop comprehensive, goal-directed plans with individuals and their caregivers that assess and address all aspects of a person's needs, including physical, cognitive, communicative and psychosocial issues. These interventions help individuals adjust to new functional levels or complex conditions, adapt their skills and reintegrate into the community. [10]

Community-based rehabilitation can be categorized into the following patient/client-centred, needs-based categories. Patients/clients requiring rehabilitation may fall under more than one category concurrently:

Primary Prevention	**Primary prevention aims to prevent disease or injury before it occurs** **Rehabilitation focuses on:** • **Prevention of accidents, injuries and/or diseases** • **Promotion of health lifestyle and aging**
Post-Injury / Illness	**Requires rehabilitation as a result of a recent loss of functional ability following a medical event/decline in health or an acute event** **Rehabilitation focuses on:** • **Reversal or stabilization of a decline in health status** • **Maximization of recovery, return to previous level of function, when possible, and reintegration into meaningful activities** • **Secondary prevention to prevent re-injury or recurrence**
Progressive / Chronic Conditions	**Requires rehabilitation as a result of a chronic condition** **Rehabilitation focuses on:** • **Achieving and maintaining functional improvements, quality of life and self-management** • **Reduced caregiver burden** • **Pain & symptom management and end-of-life care** • **Tertiary prevention to soften the impact of symptoms of ongoing illness or injury**

Evidence shows that rehabilitation provided along a continuum of care from hospital to home and community (or from community to a bedded level of rehabilitative care) can improve health outcomes, reduce costs by shortening hospital stays, reduce disability and improve quality of life for patients/clients and their caregivers.[11] [12] Community-based rehabilitative care results in both patient/client and system-level outcomes. [13] It also contributes to seamless transitions and supports individuals to live successfully in community settings. [14] For example:

- **Early supported discharge to rehabilitative care in the home is recommended for patients/clients recovering from mild to moderate stroke;** it is intended as an alternative to a complete course of inpatient rehabilitation and may serve as a transition point to outpatient or community stroke rehabilitation. Services should be provided five days per week at the same level of intensity as in the inpatient setting. [15] Following stroke, people with ongoing rehabilitation goals should continue to have access to specialized stroke services after leaving hospital [Evidence Level A].[16] [17]

- This should include facility-based outpatient services and/or in-home rehabilitation services [Evidence Level A].
- **Timely access to specialized community-based rehabilitation** is recommended for individuals with ongoing disability after traumatic brain injury to facilitate continued progress and successful community reintegration. [18]
- **Community-based rehabilitation can reduce the need for more invasive surgical procedures.** For example, lumbar spinal stenosis treated through outpatient physiotherapy was as successful as surgery, with 15 per cent fewer complications; [19] up to 75 per cent of people with a full tear in their rotator cuff had their shoulder issues resolve through rehabilitation, avoiding the need for surgery; [20] and outpatient physiotherapy for meniscal tears helped 60-70 per cent of knee OA patients avoid surgery. [21]
- **Patients/clients with chronic conditions benefit from rehabilitative care.** These patients/clients are high users of health care; in Canada, 70% of Canadians 45 years or over have two or more chronic diseases and 80% of adult visits to GPs in Canada are due to chronic disease management. [22] Rehabilitative care has been shown to be effective in the prevention and management of chronic conditions (e.g., hypertension, emphysema, Type 2 Diabetes, Parkinson's, multiple sclerosis, arthritis) and optimizing quality of life. [23] Individuals with chronic disease who receive outpatient/community rehabilitation have improved outcomes, lower utilization of costly health services and reduced hospital admissions/readmissions. [24] People with chronic conditions are supported through self-management techniques to decrease their symptoms, improve their daily function, [25 26 27] and reduce potential opioid use.[28]
- **Older adults experiencing falls** accounted for over 65% of injury-related hospitalizations among those over 65 to 74 years of age and over 80% for those over 75 years. Moreover, falls represent the leading cause of injury-related emergency department visits and hospital admissions among older adults in Canada. [29] Rehabilitative care in the forms of multifactorial risk assessment, multiple-component group and home-based exercise programs, and home safety assessment and modifications, are effective in reducing the rate and/or risk of falls. [30 31] It is also important to note that hearing loss is one of the risk factors for falls with the risk factor increasing substantially relative to small increments of hearing loss (i.e., 140% increased risk for every 10 decibels of hearing loss.) [32] Approximately one-third of older adults who fall also report hearing difficulties. [33] Age-related changes can also include poorer balance due to changes in the vestibular system. Audiologists play a key role in the assessment and management of hearing as well as screening for falling risk. [34]
- **Older adults wishing to age in place** can benefit from individualized rehabilitative care services, such as occupational therapy or physiotherapy, to increase or maintain their level of independence with activities of daily living including self-care activities (e.g., dressing, bathing, toileting, walking) as well as home and community living skills (e.g., shopping, communicating with family and friends, food preparation) and also reduce the need for conventional home care supportive services. The focus of the rehabilitative care services may include optimizing strength, balance and endurance; chronic disease self-management; nutrition management; identifying assistive devices and modifications to the home environment to increase safety; and providing strategies to reduce social isolation. [35 36]

Although health promotion/prevention programs that are not provided by or supervised under regulated health professionals are not included in this framework, it is acknowledged that such programs may be integrated into the services provided by regulated health care professionals. In addition, these programs play an important role in the system by promoting overall health and supporting patients'/clients' reintegration in the community. [37]

For more information on community-based rehabilitative care, see the RCA's White Paper on Community Rehabilitation.

4. ROLE OF PRIMARY PREVENTION

Primary prevention aims to prevent disease or injury before it occurs by preventing exposure to hazards that cause disease or injury, altering unhealthy or unsafe behaviours that can lead to disease or injury and increasing resilience to disease or injury should exposure occur. In the area of outpatient/community rehab, primary prevention efforts often focus on two key areas: fall and injury prevention. [38]

Fall Prevention:

As noted earlier, falls represent the leading cause of injury-related emergency department visits and hospital admissions among older adults in Canada. In Ontario, they accounted for over 65% of injury-related hospitalizations among adults ages 65 to 74 and over 80% for those over 75 years. [39] Rehabilitative care programs that include balance and functional exercises, case management, and treatment of vision and hearing loss [40] have resulted in lower rates of fall-related injuries. [41] According to the World Guidelines (2022) for falls prevention and management for community-dwelling older adults, "all older adults should be advised on falls prevention and physical activity". In addition, "those considered at high risk should be offered a comprehensive multifactorial falls risk assessment with a view to co-design and implement personalised multidomain interventions." [42]

Injury and Trauma Prevention:

Injury prevention refers to strategies, policies or programs designed to eliminate or reduce the occurrence and severity of injuries. Two primary areas of focus are initiatives that target young people and also workplace injuries.

5. VIRTUAL CARE

Virtual care is defined as “any interaction between patients/clients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies (e.g., telephone, videoconferencing or sensor monitoring) with the aim of facilitating or maximizing the quality and effectiveness of patient/client care.” [43] It has been used for a number of years in some areas of rehabilitative care, such as providing services in rural and remote communities with positive health outcomes,[44] but has been accelerated during the pandemic. There are several benefits of providing virtual rehabilitation for patients/clients and clinicians. These include: [45]

- Increasing access to specialized rehab therapists/services:
    - for those living in remote communities or in areas where transportation options are not available/feasible
    - where they are not available locally. (Note: Occupational Therapist Assistants, Physical Therapist Assistants and Communication Disorder Assistants can be used on site to support the therapy provided virtually.)
    - for patients/clients who do not have the tolerance to attend an onsite treatment session (e.g., patients/clients with post-COVID-19 condition)
- Decreasing wait times to access services
- Reducing travel time for patients/clients

- Using hands on care from family/caregivers who may not have the time or resources to come into a clinic setting but could be available to participate in the virtual session. Having family/caregiver support can also mediate potential safety issues.
- Supporting local providers to provide specialized rehab services

There are also challenges with providing virtual rehabilitation and therefore virtual rehabilitation is not always an appropriate or full substitute for in-person rehabilitation. Barriers to using virtual rehabilitation may include: [46] [47] [48] [49]

- the patient's/client's lack of equipment and/or comfort with using technology or lack of privacy
- the absence of contextual factors that are more available during in-person sessions,
- limitations around safety (e.g., hands-on assistance with exercises), and
- limitations in the ability to conduct some assessments and interventions
- difficulty with hearing and vision or language barriers, and the impact this will have on their ability to participate
- the patient's/client's cognitive ability and how it may impact their safety, ability to complete a self-directed program and the carry-over advice that is provided

It is therefore important to select patients/clients carefully. Not every patient/client or every patient's/client's goals are suitable for the virtual format and the decision to use a virtual format should be considered on a case-by-case basis using professional clinical judgment [50] (and where possible, determined by an initial face-to-face discussion/assessment). Consideration can be given to the use of virtual or in-person sessions in an individual or group format, or a mix of the two formats depending on the patient's/client's resources, needs, and goals. For example, depending on the complexity of the patient/client and the clinician's clinical judgment, a patient/client might be seen virtually for all sessions or for a mix of virtual and face-to-face sessions. The clinician might also use a mix of asynchronous visits (e.g., a caregiver could provide a short video to give the therapist some information or the therapist could use it to provide some information) and the therapist can follow-up with the patient/client afterwards.

For further information on the use of virtual rehab, see the RCA's White Paper on Community Rehabilitation. See also RCA Virtual Rehabilitation Resources

6. ELIGIBILITY CRITERIA FOR COMMUNITY-BASED REHABILITATIVE CARE

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

- The patient/client has restorative potential*, (i.e., There is reason to believe, based on clinical assessment and expertise and evidence in the literature where available, that the patient's/client's condition is likely to undergo functional improvement and benefit from rehabilitative care) or requires rehabilitative care to prevent functional decline *and*
- The patient/client is medically stable enough such that the patient/client is able to participate in and benefit from rehabilitative care (i.e., carry-over for learning) within the context of their specific functional goals; *and*
- The patient/client has identified goals that are specific, measurable, realistic and timely. Rehabilitation goals can be met or reasonably equivalent gains can be achieved: [51]

- Independently in collaboration with the rehabilitative care provider
- With caregiver education, training and support, and
- Through self-care/wellness/health promotion classes

*Restorative Potential

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

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

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

7. RCA COMMUNITY-BASED LEVELS OF REHABILITATIVE CARE – CONCEPTUAL FRAMEWORK

When considering community-based rehabilitative care for your patient/client:

STEP 1: Determine which level of community-based rehabilitative care would meet the needs of the patient/client based on the functional trajectory of treatment (i.e., progression vs. maintenance)

STEP 2: Determine the location of community-based rehabilitative care. Where a patient/client receives community-based rehabilitative care (in the community, in-home or in a primary care setting) should be based on which environment is most appropriate and safe given the patient's/client's rehabilitative goals, their preferences and the caregiver supports available to them. Other considerations include resource/equipment needs, individual or group format, in-person or virtual care treatment, the capacity and safety of patients/clients to travel outside of the home and availability of services. [52]

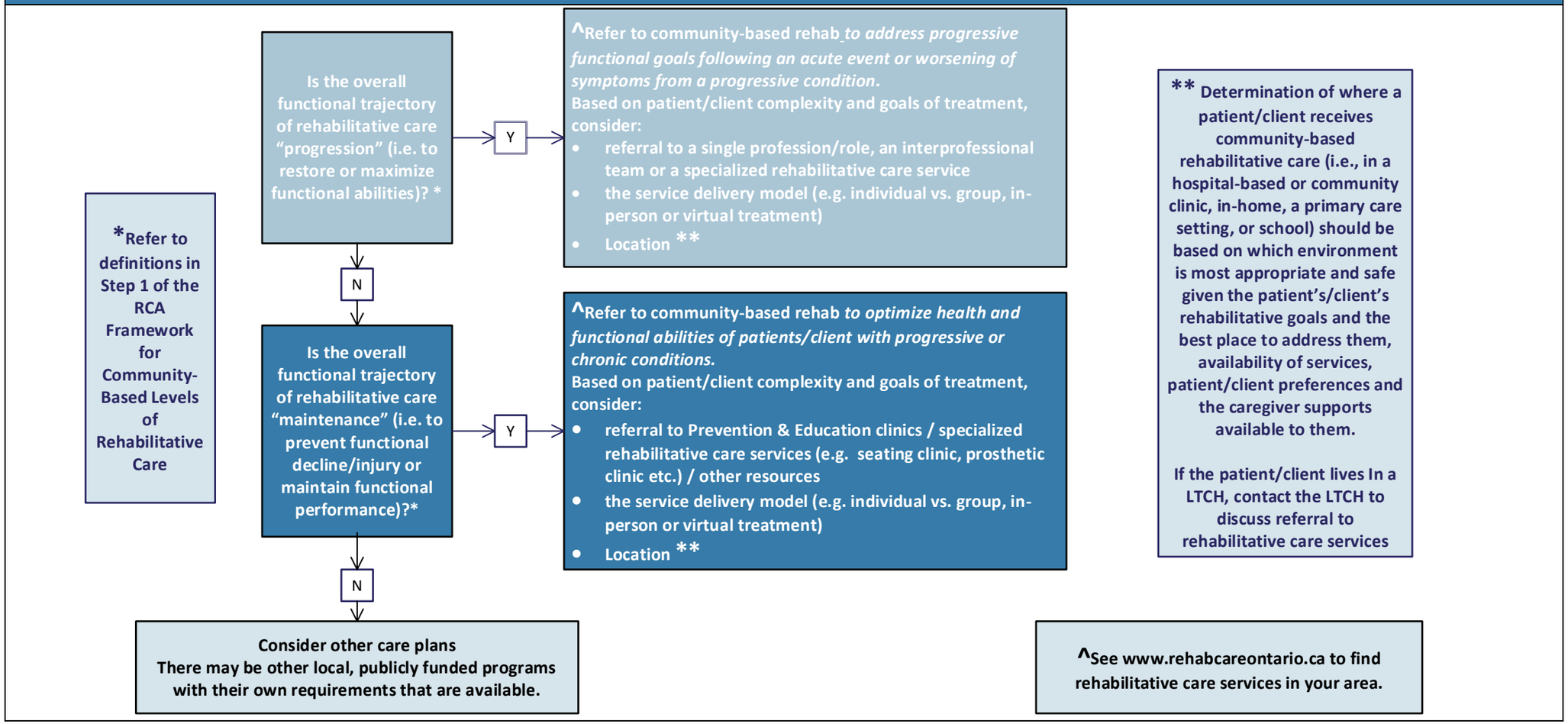
RCA FRAMEWORK FOR COMMUNITY-BASED LEVELS OF REHABILITATIVE CARE		
These definitions pertain to publicly-funded programs (i.e., OH or MOH funded) with a primary rehabilitative care focus provided by or under the supervision of regulated health professionals. However, it is recognized that non-regulated providers (e.g., recreation therapists, rehabilitation assistants and communication disorder assistants) are important members of rehabilitation teams and services. [53]		
STEP 1: Determine which level of community-based rehabilitative care would meet the needs of the patient/client based on the functional trajectory of treatment (i.e., progression vs. maintenance)		
	Functional Trajectory: Progression	**Functional Trajectory: Maintenance**
Level of Care - Goal		
Target Population & Functional Characteristics		
Transition Indicator		
Rehabilitative Care Provision		
Medical Care		
Healthcare Professionals		
Therapy Intensity		
A Note on Wellness/Health Promotion Post-Rehabilitation Community Reintegration		
• While wellness focused health promotion/prevention programs that are not provided by or supervised under regulated health professionals are beyond the scope of the RCA Framework for Community-Based Level of Rehabilitative Care, it is acknowledged that such programs play an important role in the system by promoting overall health and supporting patients'/clients' reintegration into the community. • These programs should be considered by providers within the defined levels of rehabilitative care when discharge planning and transitioning patients/clients to self-management activities. Examples of these programs include: Group exercise; wellness promotion classes; swimming; walk-fit; yoga; Tai-Chi; Pilates; peer support and friendly visiting programs.		

RCA FRAMEWORK FOR COMMUNITY-BASED LEVELS OF REHABILITATIVE CARE

REFERRAL DECISION TOOL FOR DETERMINING LOCATION OF COMMUNITY-BASED REHABILITATIVE CARE

***STEP 2*: Determine the location of community-based rehabilitative care**

Determination of where a patient/client receives community-based rehabilitative care (in the community, in-home or in a primary care setting) should be based on which environment is most appropriate and safe given the patient's/client's rehabilitative goals, their preferences and the caregiver supports available to them. Other considerations include resource/equipment needs, individual or group format, in-person or virtual care treatment, the capacity and safety of patients /clients to travel outside of the home and availability of services. [54]



8. RCA FRAMEWORK FOR COMMUNITY-BASED LEVELS OF REHABILITATIVE CARE

<table>
<tr><th colspan="3">RCA FRAMEWORK FOR COMMUNITY-BASED LEVELS OF REHABILITATIVE CARE

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<tr><td colspan="3">STEP 1: Determine which level of community-based rehabilitative care would meet the needs of the patient/client</td></tr>
<tr><td>Functional Trajectory</td><td>PROGRESSION</td><td>MAINTENANCE</td></tr>
<tr><td rowspan="2">Level of Care - Goal</td><td colspan="2">• Rehabilitation is focused on enabling individuals with impairments and disabilities to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels and thereby promote health and well-being, re-integration to community living and improve quality of life. [56]
• Determination of where a patient/client receives community-based rehabilitative care (in the community, in-home, primary care setting or in school) should be based on which environment is most appropriate and safe given the patient's/client's rehabilitative goals, their preferences and the caregiver supports available to them. Other considerations include resource/equipment needs, individual or group format, in-person or virtual care treatment, the capacity and safety of patients/clients to travel outside of the home and availability of services. [57]</td></tr>
<tr><td>• To provide assessment and time limited treatment through a single service or coordinated, interprofessional approach to:
○ Restore or maximize functional abilities (including cognitive and communicative capacities in all aspects of living)
○ Promote adaptation of/to the home environment to support re-integration to community and overall quality of life
○ Support timely transition from or prevent admission to acute care or a bedded level of rehabilitative care
○ Provide the opportunity to learn and practice in a familiar, stimulating and supportive environment</td><td>• To prevent functional decline/injury or maintain functional performance (e.g. strength, mobility, balance, falls prevention etc.) through:
○ Individual assessment/treatment to address functional impairments, chronic disease self-management, nutrition management, social isolation particularly among older adults [58] [59]
○ Assessment of barriers and mitigating risks to patient's/client's ability to maintain function and safety [60]
○ Education to caregivers on illness/condition and provide strategies to optimize their support efforts and to lower their stress [61]
○ Linking patients/clients to wellness-focused health promotion/prevention programs in the community (e.g., group exercise, wellness promotion classes, swimming, walk-fit, yoga, tai-chi, Pilates, peer support and friendly visiting programs)
○ Periodic assessment and oversight of care plan by regulated health professional/team to determine the need for engagement of additional rehab professionals depending on patient/client need and availability of family support or informal care networks
○ Community-based education/activity programs such as group exercise, activation, or falls prevention classes or services to maintain an existing level of function</td></tr>
<tr><td>Target Population / Functional Characteristics</td><td>• Individuals who following acute episodes or the worsening of symptoms due to a debilitating event or progressive condition including chronic disease, pain, injury or surgical procedure: [62]</td><td>• Individuals living in the community (home, retirement homes) with reduced physical/cognitive/speech-language functioning (e.g., neuromuscular, musculoskeletal and cardio-respiratory etc.) who require rehabilitative care to prevent a decline in functional status</td></tr>
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<tr><th>Functional Trajectory</th><th>PROGRESSION</th><th>MAINTENANCE</th></tr>
<tr><td rowspan="2">Target Population / Functional Characteristics</td><td>○ Have functional impairments resulting in decreased function (e.g., reduced functioning in activities of daily living, mobility, communication, cognition, swallowing etc.)
○ Require rehabilitation to achieve functional goals, increase self-management skills and maximize community reintegration
○ Do not require a bedded level of care</td><td>and/or to promote their independence with activities of daily living and their capacity to remain at home
• Individuals also include those who have functional goals that can be met by participating in group intervention, which could include fall prevention classes.</td></tr>
<tr><td colspan="2"><u>Note</u>: Some individuals, for example those who are aging with a chronic disability where a decline might be anticipated due to the nature of their health condition, may need to move between the maintenance and progression levels of rehabilitative care in the event that a new functional goal and treatment plan is identified (e.g., a patient/client with Multiple Sclerosis developing the need for an ankle foot orthosis or an aging patient/client with paraplegia who develops shoulder osteoarthritis from years of transfers).</td></tr>
<tr><td rowspan="2">Transition Indicator</td><td>Determined by the following considerations:
• When individuals have achieved their identified therapeutic objectives / functional goals as per the patient's/client's treatment plan or
• Reasonably equivalent gains can be achieved independently or with the assistance of a caregiver at home or through self-care or wellness/health promotions classes (e.g., exercise classes) or other appropriate resources in the community or
• No further gains are likely to be achieved (i.e., a plateau has been reached)</td><td>Determined by the following considerations:
• When individuals have achieved their identified therapeutic objectives / functional goals as per the patient/client's treatment plan to prevent decline in function or
• A reasonably equivalent impact can be achieved independently or with the assistance of a caregiver at home or through self-management or wellness/health promotions classes (e.g., exercise classes) or other appropriate resources in the community
• Individuals have the opportunity to transition back into the Maintenance level if intermittent assessment and/or intervention are needed.
• Individuals may transition to the Progression level of community-based rehabilitative care or to a bedded level of rehabilitative care to address the onset of a new condition or change in treatment plan</td></tr>
<tr><td colspan="2">Note: At each transition point, mechanisms for the coordination and communication of the post-discharge rehabilitative care plan with the patient/client and families/caregivers upon discharge and with the receiving provider(s) within 48 hours should be in place to support a successful transition. [63]</td></tr>
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STEP 1: Determine which level of community-based rehabilitative care would meet the needs of the patient/client		
Functional Trajectory	**PROGRESSION**	**MAINTENANCE**
Rehabilitative care provision	Rehabilitative care provided by medical, nursing and health professionals: • Is patient/client-centred [64] and based on the patient's/client's assessed care needs and goals • Includes a written plan of care for each person receiving the service • Is coordinated and uses a collaborative model of care where there are mechanisms in place to support effective case coordination/management and communication among all members of the rehabilitative care team and the primary care practitioner • Involves the patient/client, family and/or informal caregivers in care planning, with the patient's/client's consent	
Medical Care	Medical care/management may be provided by a primary care practitioner (e.g., Family Physician, Nurse Practitioner) as well as by those focused on rehabilitative care (e.g., physiatrists, geriatricians, paediatricians and/or other specialists)	

Healthcare Professionals	• Therapy services:
	  ○ Are provided by or under the supervision of a minimum of one regulated health professional or by an integrated, interprofessional team of regulated health professionals (if more than one discipline is required) with expertise in the condition(s) for which the patient/client is being treated as well as some understanding of associated pre-morbid conditions.
	  • Some programs may use therapy assistants under the supervision of a regulated health professional (e.g., PT or OT assistants) as part of the care team to increase the impact, intensity, adherence and supervision of therapy. [65]
	  • Regulated health professionals may include but are not limited to: Chiropodists, Dietitians, Kinesiologists, Occupational Therapists, Psychologists, Physiotherapists, Social Workers, Speech-Language Pathologists and Registered Nurses [66]
	• Services may include: [67]
	  ○ Assessing and developing treatment plans to address functional impairments, as needed
	  ○ Teaching specific activities/exercises to improve/restore function and progressing activity tolerance while providing reassurance/education
	  ○ Equipment prescription and recommendations for assistive devices
	  ○ Risk factor management; increasing self-management and self-efficacy skills
	  ○ Supporting timely transition from or preventing admission to an acute or rehabilitation hospital
	  ○ Addressing the patient's/client's social circumstances and linking with income, housing, transportation and food security programs
	  ○ Linking patients/clients with wellness/health promotion programs.
	  ○ Interventions to improve: ADLs; communication; cognition; swallowing; balance; lower /upper extremity strength; mobility; ability to transfer/move in bed; functional transfers; seating and positioning; behaviours; safety; coping including emotional functioning and adjustment to disability; independence and return to vocational activities
	• Services may be:	

RCA FRAMEWORK FOR COMMUNITY-BASED LEVELS OF REHABILITATIVE CARE These definitions pertain to publicly-funded programs (i.e., OH or MOH funded) with a primary rehabilitative care focus provided by or under the supervision of regulated health professionals. However, it is recognized that non-regulated providers (e.g., recreation therapists, rehabilitation assistants and communication disorder assistants) are important members of rehabilitation teams and services. [55]		
STEP 1: Determine which level of community-based rehabilitative care would meet the needs of the patient/client		
Functional Trajectory	**PROGRESSION**	**MAINTENANCE**
	○ Primarily consultative or assessment-based for assistive devices needs (e.g., seating clinics & Assistive Devices Programs; Augmentative Communication Clinics) or to address other impairments or disability (e.g., Spasticity Clinic; Vocational Rehab; Geriatric Assessment; Follow-up appointments following discharge) ○ Provided in individual or group format that are led by a regulated rehab professional or team of regulated health professionals to enhance an individual's ability to cope with impairments, activity limitations and participation restrictions. [68]	
Healthcare Professionals	• In the Progression level, therapy services: ○ Are provided to improve, develop or restore function lost or impaired as a result of de-conditioning, a health condition, pain, injury, surgical procedure or a life-altering disability. • May include intensive rehabilitation to support early discharge from hospital or to prevent admission to hospital	• In the Maintenance level, therapy services: ○ Are provided to maintain and/or to prevent a decline in functional/clinical status as a result of de-conditioning, a health condition, pain or aging • May involve intermittent re-assessment/treatment and/or periodic oversight by a regulated health professional/team to determine need for engagement of additional rehab professionals depending on patient/client need and availability of family support or informal care networks • May include falls prevention group classes provided by a regulated health professional and/or under the direction of a regulated health professional. • May involve other wellness/health promotion classes • In order to align with best practices, fall prevention programs should be comprehensive,[69] multi-factorial [70, 71, 72] and may include but are not limited to the following components: ○ Individualized risk assessment:[73] A brief risk assessment can be used to identify those who require a more comprehensive evaluation based on risk factors[74 75 76] and geriatric syndromes. Such assessments may include a review of environmental hazards, including the home;[77,78] vision screening and hearing loss; [79 80 81] medication management;[82] gait and cognitive assessment; [83] continence; nutritional assessment [84] and other risk factors. ○ Exercise: Exercise programs have been shown to reduce the risk of fall recurrence. [85 86 87 88] These programs include strength training; [89 90] balance training, [91 92] and advice on the appropriate use of assistive devices.[93] ○ Education: Education with patients/clients, caregivers and providers is recommended as part of a comprehensive approach. It is important to recognize, however, that education alone does not reduce the risk of falls. [94] Topics covered through educational efforts may

RCA FRAMEWORK FOR COMMUNITY-BASED LEVELS OF REHABILITATIVE CARE These definitions pertain to publicly-funded programs (i.e., OH or MOH funded) with a primary rehabilitative care focus provided by or under the supervision of regulated health professionals. However, it is recognized that non-regulated providers (e.g., recreation therapists, rehabilitation assistants and communication disorder assistants) are important members of rehabilitation teams and services. [55]		
STEP 1: Determine which level of community-based rehabilitative care would meet the needs of the patient/client		
Functional Trajectory	**PROGRESSION**	**MAINTENANCE**
		include: improving environmental safety, how to safely change positions, managing weather conditions, and reducing fear of falling, self-management strategies, among others.[95]
Therapy Intensity	○ The number and frequency of services are based on the treating therapist's assessment, evidence-based best practices and the patient's/client's individual needs. See the following RCA best practice guidelines: Hip Fracture Rehab Guidelines and Hip Fracture Rehab Resources Older Adults with Frailty Rehab Guidelines Total Joint Replacement Rehab Guidelines and TJR Rehab Resources	

After determining which level of community-based rehabilitative care is needed,
refer to *STEP 2* in the decision tree in Section 7, to determine location of community-based rehabilitative care.

9. 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
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