

Introduction

The Referral Options for Bedded Rehabilitative Care Programs/Services was developed by the Rehabilitative Care Alliance (RCA) to assist referrers when looking for rehabilitative care programs in bedded levels of care.

This Referral Options tool is a standardized provincial tool that provides information on rehabilitative care provided by Regulated Health Professionals (RHPs) in hospital-based designated inpatient rehab beds, complex continuing care beds and convalescent care beds that fall within the following 4 bedded levels of rehabilitative care:

- ▲ Rehabilitation
- ▲ Activation/Restoration
- ▲ Short Term Complex Medical Management
- ▲ Long Term Complex Medical Management

Standardized provincial definitions for each of these levels of rehabilitative care as well as eligibility criteria have been developed by the RCA. Key features of each of the bedded levels of rehabilitative care are described on the next page. The eligibility criteria for bedded levels of rehabilitative care can be found in the Appendix section. For full details, see the complete [Definitions Framework for Bedded Levels of Rehabilitative Care](#).

While this resource was developed as a standardized provincial tool, each LHIN has adapted the tool to provide information on rehabilitative care within its region.

This checklist highlights the key features of the bedded levels of rehabilitative care to help you determine which level best meets the rehabilitative care needs of your patient. Full descriptions of the levels are available at <http://rehabcarealliance.ca/definitions-1>

<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Activation/Restoration	<input type="checkbox"/> Short-Term Complex Medical Management	<input type="checkbox"/> Long-Term Complex Medical Management
<p style="text-align: center;">Functional Goal: <u>Progression</u></p> <p><i>Time-limited, coordinated interprofessional rehabilitation plan of care ranging from low to high intensity through a combined and coordinated use of medical, nursing and allied health professional skills.</i></p> <p>Target Population: Medically stable, able to participate in comprehensive rehabilitation program</p> <p>Average LOS: <90 Days. Based on best practice targets and discharge indicator considerations. Rehab team to confirm LOS for specific program.</p> <p>Discharge Indicator: Rehab goals met, access to MD/nursing care no longer required</p> <p>Medical Care: Daily physician access</p> <p>Nursing Care: Up to 3 hrs/day. Some may go up to 4 hrs.</p> <p>Therapy Care: Direct care by regulated health professionals and as assigned to non-regulated professionals</p> <p>Therapy Intensity: 15-30 mins of therapy 3x/day to 3 hrs/day. Based on patient's tolerance.</p>	<p style="text-align: center;">Functional Goal: <u>Progression</u></p> <p><i>Exercise and recreational activities offered to increase strength and independence. Goal achievement does not require daily access to a full interprofessional rehabilitation team & coordinated team approach.</i></p> <p>Target Population: Medically stable, cognitively and physically able to participate in restorative activities</p> <p>Average LOS: (56-72 days) <90 Days</p> <p>Discharge Indicator: Rehab goals met, access to MD/nursing care no longer required</p> <p>Medical Care: Weekly physician access/follow-up</p> <p>Nursing Care: <2 hrs/day</p> <p>Therapy Care: Consulted by regulated health professionals, delivered mostly by non-regulated professional as assigned</p> <p>Therapy Intensity: Group or 1:1 setting, throughout the day 30 mins or up to 2 hrs/day (5-7 days/week).</p>	<p style="text-align: center;">Functional Goal: <u>Stabilization & Progression</u></p> <p><i>Medically complex and specialized services to avoid further loss of function, increase activity tolerance and progress patient.</i></p> <p>Target Population: Medically complex with long-term illnesses/disabilities, requiring on-going medical/nursing support. On admission, may have limited physical and/or cognitive capacity due to medical complexity but believed to have restorative potential.</p> <p>Average LOS: Up to 90 Days</p> <p>Discharge Indicator: Medical/functional recovery to allow patient to safely transition to next level of rehab care or alternate environment</p> <p>Medical care: Access to scheduled physician care/daily medical oversight</p> <p>Nursing Care: >3hrs /day</p> <p>Therapy Care: Regulated health professionals to maintain/maximize cognitive, physical, emotional, functional abilities. Supported by non-regulated health professionals as assigned.</p> <p>Therapy Intensity: Up to 1 hr, as tolerated by the patient</p>	<p style="text-align: center;">Functional Goal: <u>Maintenance</u></p> <p><i>Medically complex and specialized services over an extended period of time to maintain/slow the rate of, or avoid further loss of, function</i></p> <p>Target Population: Medically complex with long-term illnesses/disabilities, requiring on-going medical/nursing support that cannot be met at home or in a LTCH</p> <p>Average LOS: Will remain at this level</p> <p>Discharge Indicator: Patient is designated to be more or less a permanent resident in the hospital and will remain until medical/functional status changes</p> <p>Medical care: Access to weekly physician follow up/oversight – up to 8 monitoring visits per month</p> <p>Nursing Care: >3hrs /day</p> <p>Therapy Care: Regulated health professionals to maintain/maximize cognitive, physical, emotional, functional abilities. Supported by non-regulated health professional as assigned.</p> <p>Therapy Intensity: Regulated health professional available to maintain and optimize functional abilities.</p>

<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Activation/Restoration	<input type="checkbox"/> Short-Term Complex Medical Management	<input type="checkbox"/> Long-Term Complex Medical Management
<i>Functional Goal:</i> <u>Progression</u>	<i>Functional Goal:</i> <u>Progression</u>	<i>Functional Goal:</i> <u>Stabilization & Progression</u>	<i>Functional Goal:</i> <u>Maintenance</u>
<p>Program Name: Rehabilitation, high and low intensity, Joseph Brant Hospital (JBH)</p> <p>Location: 1230 North Shore Blvd, Burlington, ON.</p> <p>Number of beds: 44 beds</p> <ul style="list-style-type: none"> 14 high Intensity rehab beds located on the 6th floor. 30 low intensity rehab beds, 23 located on the 6th floor, 7 located on 4E. <p>Referral Process:</p> <p>High Intensity Referrals: Complete the HNHB LHIN Acute Care to Rehab & Complex Care Referral. Include consult notes and Allied Health assessments and progress notes. Fax to 905-681-4849</p> <p>Low Intensity Referrals: Complete the HNHB LHIN Acute Care to Rehab & Complex Care Referral package and Letter of Understanding. Include consult notes and Allied Health assessments and progress notes. Fax to CCAC 905-639-6688</p> <p>Contact Information: 905-336-4132</p>	<p>Program Name: Convalescent Care Program (CCP), Wellington Park Care Centre (WPCC)</p> <p>Location: 802 Hager Ave., Burlington, ON.</p> <p>Number of beds: 19 beds (includes 13 assess restore and 6 reactivation).</p> <p>Referral Process: Referral is completed by hospital allied health team if patient is in hospital. The Assessment is completed by an HNHB Care Coordinator with patient in hospital or in community/ home setting.</p> <p>Hospitals should fax a referral to the CCAC office --- 905-637-7668 or send the referral electronically through Meditech.</p> <p>Community partners should telephone the CCAC at 1-866-790-4642 to request a referral.</p> <p>Community Contact information: 905-639-5228 or 1-800-810-0000</p>	<p>Program Name: Complex care, medically complex, Joseph Brant Hospital (JBH)</p> <p>Location: 1230 North Shore Blvd., Burlington, ON, 4 East</p> <p>Number of beds: 6 beds in total</p> <p>Patient Population: Patient's that are receiving blood transfusions on a regular basis, receiving dialysis, receiving radiation treatments, ongoing IV management, and individuals with complex wounds.</p> <p>Referral Process: Complete the HNHB LHIN Acute Care to Rehab & Complex Care Referral package and Letter of Understanding. Include consult notes and Allied Health assessments and progress notes.</p> <p>Fax to CCAC 905-639-6688</p> <p>Contact Information: 905-336-4111</p>	

Appendix

Eligibility Criteria for Bedded Rehabilitative Care

- 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 stable such that s/he 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 participate in and benefit from rehabilitative care (i.e., carry-over for learning) within the context of his/her specific functional goals (See note);
Note: Patients being considered for short term complex medical management may not demonstrate carry-over for learning at the time of admission, but are expected to develop carry-over through the course of treatment in this level of care.
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 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, delirium or discharge destination should not be used in isolation to influence a determination of restorative potential.