Definitions Framework for Bedded Levels of Rehabilitative Care

The mandate of the Definitions Task Group is to develop standardized definitions that describe rehabilitative care resources across the continuum, including a system-wide Assess and Restore approach.[i] The first phase of this work has focused on the development of the Definitions Framework for Bedded Levels of Rehabilitative Care, included here. The Definitions Task Group is currently developing standardized definitions for community-based levels of rehabilitative care.

The Definitions Framework for Bedded Levels of Rehabilitative Care is a foundational document that defines (1) the bedded levels of rehabilitative care[ii] and (2) the recommended standard components and human resources within each of these levels 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 LHINs as part of a capacity planning process to evaluate rehabilitative care resources within the context of specific patient and local/regional programming needs.

This framework builds on and aligns with functional groups identified by the Provincial Expert Panel's Definitions Working Group and has been prepared with input from committee members of the Definitions Task and Advisory Groups, the Frail Seniors/Medically Complex Task and Advisory Groups and the LHIN Leads/Health Service Providers Advisory Group, each of which include medical, clinical and administrative stakeholders from across organizations and LHINs. 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 Definitions Framework for Bedded Levels of Care, determine if their programs offered in rehab, complex continuing care and convalescent care beds (in LTCH) align with the levels of rehabilitative care within the framework and provide feedback on the framework and definitions.

The objectives in developing a provincial Definitions Framework are 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

[i] An Assess and Restore approach refers to Assess and Restore *interventions* that are provided to a defined population of high-risk, frail seniors who have experienced a recent loss of functional ability following a medical event or decline in health; are at high risk for imminent hospitalization or admission into a long-stay Long-Term Care (LTC) home bed as a result of that functional loss; and who have restorative potential, i.e., they have the potential to regain that functional loss so that they are no longer at high risk. These interventions are delivered within and across a range of existing programs and levels of care, including but not limited to the bedded levels of rehabilitative care described in this framework.

[ii] 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.

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

- Solutions developed by the 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.

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

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.[4] 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.

Conceptual Framework – Bedded Levels of Rehabilitative Care

DEFINITIONS 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 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).

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.

Bedded Levels of Rehabilitative Care

(i.e. Hospital-based designated inpatient rehab beds and complex continuing care beds as well as convalescent care beds within LTCH)

		Rehabilitation (Low to high intensity)	*Activation /Restoration*	*Short Term Complex Medical Management*	*Long Term Complex Medical Management*
Functional Trajectory		Progression	Progression	Stabilization & Progression	Maintenance
Level of Care - Goal					
Patient Characteristics	***Target Population***				
	Functional Characteristics				
	Estimated Average LOS				
	Discharge Indicator				
Medical/Allied Health Resources	***Medical Care***				
	Nursing Care				
	Therapy Care				
	Intensity of Therapy				
Reporting Tools					

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		Rehabilitation ***(Low to high intensity)***	***Activation / Restoration***	***Short Term Complex Medical Management***	***Long Term Complex Medical Management***
	Functional Trajectory	Progression	Progression	Stabilization & Progression	Maintenance
Patient Characteristics	***Level of Care - Goal***	• *To develop and provide* ***a 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.***[5] Rehabilitation is focused on enabling, individuals with impairments and disabilities to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. [6]	• 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 environment or other appropriate community environment. 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.	• 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 (rehabilitative) care wherever possible.[7 8]	• 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 continuing care and is, and will continue to be more or less a permanent resident in the hospital". [9]

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Bedded Levels of Rehabilitative Care
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		Rehabilitation ***(Low to high intensity)***	***Activation / Restoration***	***Short Term Complex Medical Management***	***Long Term Complex Medical Management***
Patient Characteristics	***Target Population***	Patients who: • Are medically stable with significant functional impairments and who require and are able to participate in a comprehensive interprofessional rehabilitation program at a low to high intensity to enhance functional and cognitive ability. Note: All patients who 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. • May be at high risk of permanent loss of living independently in the community.	Patients who: • 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. • Patients are expected to have a discharge location, typically home. Some patients could be preparing for active rehabilitation before returning home.[10]	Patients who: • Are medically complex, with longer-term illnesses or disabilities typically requiring: ○ Ongoing medical / nursing support; ○ Skilled, technology-based care not available at home or in long-term care facilities.[11] ○ Assessment and active care management by specialized interprofessional teams.[12] [13] [14]	
				Patients who: • On admission, typically 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.	
		May require access to a physician on a 24/7 on-call basis			

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Bedded Levels of Rehabilitative Care
(i.e. Hospital-based designated inpatient rehab beds and complex continuing care beds as well as convalescent care beds within LTCH)

<table>
<tr><th colspan="2"></th><th>Rehabilitation
(Low to high intensity)</th><th>Activation / Restoration</th><th>Short Term Complex Medical Management</th><th>Long Term Complex Medical Management</th></tr>
<tr><td rowspan="2">Patient Characteristics</td><td>Functional Characteristics</td><td colspan="2">Patients:
• 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;[15]
• Have identified goals for rehabilitation that are specific, measurable, attainable, realistic, and time-limited, which cannot otherwise be met in the community.
• 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.</td><td colspan="2">Patients:
• 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; medication needs have been determined; and there is an established plan of care;[16] however, some patients may experience temporary fluctuations in their medical status, which may require changes to medications/plan of care.</td></tr>
<tr><td colspan="2">• 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.
• Although the patient's initial functional tolerance may fluctuate, the patient has the cognitive ability and the physical tolerance to</td><td>• 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.
• 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 Medical/Allied Health Resources</td><td>Patients:
• Require skilled nursing and medical care that cannot be met on an ongoing basis in other levels of rehabilitative care
• 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,</td><td>Patients:
• Require skilled nursing and medical care that cannot be met on an ongoing basis in LTC or other community setting
• For whom it is anticipated, due to limited physical and/or cognitive capacity, that the degree of additional functional gain will be low</td></tr>
</table>

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(i.e. Hospital-based designated inpatient rehab beds and complex continuing care beds as well as convalescent care beds within LTCH)

		Rehabilitation (Low to high intensity)	***Activation / Restoration***	***Short Term Complex Medical Management***	***Long Term Complex Medical Management***
Patient Characteristics	***Functional Characteristics***	participate in and progress through *low or higher intensity rehabilitation* (as described in Medical/Allied Health Resources section) • Patients are expected to return to their previous living environment or other appropriate community environment following participation in rehabilitation	section) • Patients are expected to have a discharge location, typically home. Some patients could be preparing for active rehabilitation before returning home.[17]	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)	
	Estimated Average LOS	• Rarely to exceed 90 days • Consider best practice targets where available	• On average, 56 -72 days[18], but may be 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. • 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[19] Note for Rehabilitation Level of Care only: A small proportion of these patients may require discharge to an alternate care facility if:[20] • 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 • 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		• 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. • 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.

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		Rehabilitation (Low to high intensity)	***Activation / Restoration***	***Short Term Complex Medical Management***	***Long Term Complex Medical Management***
Medical/Allied Health Resources	***Discharge Indicator***	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* • 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. [21]			
	Medical Care	Physician assessment on admission 24/7 on-call physician			
		• 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 • Up to 8 monitoring visits per month[22]
	Nursing Care	• Typically, requires up to 3 hours nursing care per day; however, some patients may require up to 4 hours per day	• Requires nursing care ≤ 2 hours/day.	• Requires nursing care > 3 hours/day	

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		Rehabilitation ***(Low to high intensity)***	***Activation / Restoration***	***Short Term Complex Medical Management***	***Long Term Complex Medical Management***
Medical/Allied Health Resources	***Therapy Care***	• Direct daily therapy (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. • The interprofessional team should include: 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.	• 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[23] 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)	• 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

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		Rehabilitation ***(Low to high intensity)***	***Activation / Restoration***	***Short Term Complex Medical Management***	***Long Term Complex Medical Management***
Medical/Allied Health Resources	***Therapy Care***	• Ideally, consultation is available from all of the following professionals: Chaplain/pastoral care provider, chiropodist, psychiatrist and/or geriatric psychiatrist, psychologist and/or neuropsychologist, recreation therapist, neurologist and wound care specialist. [24] [25] • 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.[26]	• On-site therapy resources are limited to: ○ Physiotherapy (limited to providing an exercise program of 15 min/day on a 1:1 basis) ○ Non-regulated Activation / Recreational staff ○ Nursing ○ Social worker ○ Dietitian ○ Occupational Therapy and Speech Language Therapy may be available on a consultation basis.		
	Intensity of Therapy	• To accommodate differing levels of tolerance among patients on admission and increases in tolerance during the inpatient stay, the intensity of rehab may vary from low to high intensity (from at least 15 – 30 minutes of therapy 3x per day to 3	• Restorative activities may be provided in a group or 1:1 setting throughout the day (i.e. 30 minutes or up to 2 hours per day)[28] 5 – 7 days per week	• Up to 1 hour of rehabilitative activities as tolerated based on the patient's medical condition/tolerance.	• Regulated health professionals are available to maintain and optimize cognitive, physical, emotional and functional abilities

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		Rehabilitation ***(Low to high intensity)***	***Activation / Restoration***	***Short Term Complex Medical Management***	***Long Term Complex Medical Management***
	Intensity of Therapy	hours per day) up to 7 days per week. • As a patient's tolerance level improves to a level where s/he can participate in a higher intensity rehab program, the program should ideally be able to increase therapy hours as the patient's tolerance increases to achieve all patient goals.[27]			
	Reporting Tools	• NRS* (*The LTLD population will be assessed under CCRS until an additional group reflecting this population is included in the NRS grouper.)	• CCRS-CCC/CCRS-LTC	• CCRS-CCC	

Endnotes

[1] See Definitions Task Group Backgrounder Document, October 2013. http://rehabcarealliance.ca/uploads/File/Toolbox/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).
[4] GTA Rehab Network. Inpatient Rehab/LTLD Referral Guidelines. 2009.
[5] Australian Faculty of Rehabilitation Medicine (2011). Standards for the Provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals.
[6] World Health Organization, 2007
[7] Sinha, Samir K. Living Longer, Living Well. December 2012.
[8] Ministry of Health and Long Term Care (2013). Assess and Restore Policy for High Risk Older Adults – Overview Deck.
[9] MOHLTC, Hospital Complex Continuing Care (CCC) Co-payment, Questions and Answers, Resource to LHINs and Hospitals, Updated May 2010.
[10] Admission to Long-Term Care Homes, Community Care Access Centres Client Services Policy Manual. http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm_sec_11/11-10.html
[11] Ontario Ministry of Health and Long Term Care. Complex Continuing Care Co-payment 2010. Retrieved on Sept 24, 2013 from http://www.health.gov.on.ca/en/public/publications/chronic/chronic.aspx
[12] MOHLTC, Hospital Complex Continuing Care (CCC) Co-payment, Questions and Answers, Resource to LHINS and Hospitals, Updated May 2010.
[13] Mississauga Halton LHIN. Post Acute Service Framework. 2009.
[14] Ontario Hospital Association. Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System. May 2006.
[15] GTA Rehab Network. Inpatient Rehab/LTLD Referral Guidelines. 2009.
[16] GTA Rehab Network. Inpatient Rehab/LTLD Referral Guidelines. 2009.
[17] Admission to Long-Term Care Homes, Community Care Access Centres Client Services Policy Manual. http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm_sec_11/11-10.html
[18] Patients admitted to LTCH as a short-stay resident in a convalescent care bed are anticipated to return to his/her residence within 90 days. See Long-Term Care Homes Act, 2007, O. Reg. 79/10, s. 188 (4).
[19] GTA Rehab Network, Discharge Planning Guidelines for Inpatient Rehabilitation. 2009.
[20] GTA Rehab Network, Discharge Planning Guidelines for Inpatient Rehabilitation. 2009.
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