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.

Brant Referral Options for Bedded Rehabilitative Care Programs/Services

June 2016 (*Rev. July 2017*)

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

☐ Rehabilitation	☐ Activation/Restoration	☐ Short-Term Complex Medical Management	☐ Long-Term Complex Medical Management
Functional Goal: *Progression* *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.* **Target Population:** Medically stable, able to participate in comprehensive rehabilitation program **Average LOS**: <90 Days. Based on best practice targets and discharge indicator considerations. Rehab team to confirm LOS for specific program. **Discharge Indicator:** Rehab goals met, access to MD/nursing care no longer required **Medical Care:** Daily physician access **Nursing Care:** Up to 3 hrs/day. Some may go up to 4 hrs. **Therapy Care:** Direct care by regulated health professionals and as assigned to non-regulated professionals **Therapy Intensity:** 15-30 mins of therapy 3x/day to 3 hrs/day. Based on patient's tolerance.	***Functional Goal:*** *Progression* *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.* **Target Population:** Medically stable, cognitively and physically able to participate in restorative activities **Average LOS**: (56-72 days) <90 Days **Discharge Indicator:** Rehab goals met, access to MD/nursing care no longer required **Medical Care:** Weekly physician access/follow-up **Nursing Care: <**2 hrs/day **Therapy Care:** Consulted by regulated health professionals, delivered mostly by non-regulated professional as assigned **Therapy Intensity:** Group or 1:1 setting, throughout the day 30 mins or up to 2 hrs/day (5-7 days/week).	***Functional Goal:*** *Stabilization & Progression* *Medically complex and specialized services to avoid further loss of function, increase activity tolerance and progress patient.* **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. **Average LOS**: Up to 90 Days **Discharge Indicator:** Medical/functional recovery to allow patient to safely transition to next level of rehab care or alternate environment **Medical care:** Access to scheduled physician care/daily medical oversight **Nursing Care:** >3hrs /day **Therapy Care:** Regulated health professionals to maintain/maximize cognitive, physical, emotional, functional abilities. Supported by non-regulated health professionals as assigned. **Therapy Intensity:** Up to 1 hr, as tolerated by the patient	***Functional Goal:*** *Maintenance* *Medically complex and specialized services over an extended period of time to maintain/slow the rate of, or avoid further loss of, function* **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 **Average LOS**: Will remain at this level **Discharge Indicator:** Patient is designated to be more or less a permanent resident in the hospital and will remain until medical/functional status changes **Medical care:** Access to weekly physician follow up/oversight – up to 8 monitoring visits per month **Nursing Care:** >3hrs /day **Therapy Care:** Regulated health professionals to maintain/maximize cognitive, physical, emotional, functional abilities. Supported by non-regulated health professional as assigned. **Therapy Intensity:** Regulated health professional available to maintain and optimize functional abilities.

☐ Rehabilitation	☐ Activation/Restoration	☐ Short-Term Complex Medical Management	☐ Long-Term Complex Medical Management
Functional Goal: *Progression*	***Functional Goal:*** *Progression*	***Functional Goal:*** *Stabilization & Progression*	***Functional Goal:*** *Maintenance*
Program Name: Rehabilitation care, Brant Community Healthcare System (BCHS) **Location:** 200 Terrace Hill St., Brantford, ON N3R 7S9 **Number of Beds**: **25 High Intensity beds** (Rehab unit – 15 beds, Integrated Stroke Unit – 10 beds) **Program Description:** Patients in this stream have defined rehabilitation goals and are cognitively and physically able to participate in a time-limited, coordinated inter-professional rehabilitation plan of care ranging from low to high intensity through a combined and coordinated use of medical, nursing and allied health skills. **Referral Process:** Program eligibility is assessed and determined by Physiatrist and Rehab team. Referrals can be initiated through Meditech order entry from BCHS Navigation office, or completion of the HNHB LHIN Acute to Rehab and Complex Care (CCC) form. **Contact**: Group Leader ISU/Rehab, BCHS, 519-751-5544 ext. 2770 **Number of Beds**: **19 Low Intensity beds** (Reactivation) **Referral Process:** Program eligibility is assessed and determined by Community Care Access Centre (CCAC). Referrals can be initiated through Meditech order entry from BCHS Navigation office. **Contact**: Group Leader CCIP, BCHS, 519-751-5544 ext. 2787	**Program Name:** Complex Care Integrated Program (CCIP), Brant Community Healthcare System (BCHS) **Location:** 200 Terrace Hill St., Brantford, ON N3R 7S9 **Number of Beds**: **15 beds** (Assess Restore includes 9 beds on B2 and 6 beds on C4) **Program Description:** Patients in this stream are medically stable, cognitively and physically able to participate in restorative activities to increase strength and independence. Contact program for additional information. **Referral Process:** Program eligibility is assessed and determined by Community Care Access Centre (CCAC). Referrals can be initiated through Meditech order entry from BCHS Navigation office. **Contact:** Group Leader ISU/Rehab, BCHS, 519-751-5544 ext. 2770 **Contact:** Group Leader CCIP, BCHS, 519-751-5544 ext. 2787	**Program Name:** Complex Care Integrated Program (CCIP), Brant Community Healthcare System (BCHS) **Location:** 200 Terrace Hill St., Brantford, ON N3R7S9 **Number of Beds**: **13 beds** *End of Life (EOL) beds are excluded from this stream. **Program Description:** The Complex Care Integrated Program program provides services for patients who have long term illnesses / disabilities requiring on-going medical / nursing support. Patients in this stream have completed their acute phase of their illness and no longer require acute daily medical intervention by a physician. Contact program for additional information **Referral Process:** Program eligibility is assessed and determined by Community Care Access Centre (CCAC). Referrals can be initiated through Meditech order entry from BCHS Navigation office. **Contact:** Group Leader CCIP, BCHS 519-751-5544 ext. 2787	

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.