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

☐ **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.

Hamilton Referral Options for Bedded Rehabilitative Care Programs/Services

☐ 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: Medical Rehabilitation Program, St. Joseph's Healthcare Hamilton ***Location:*** 50 Charlton Ave. East, Hamilton, ON L8N 4A6 ***Number of Beds:*** 20 ***Program Description:*** The Medical Rehabilitation Program is supported by a multi-disciplinary professional team. Enrolled patients have attainable functional goals. Patients enrolled in the program can participate in a treatment regimen that includes daily interaction with multiple therapeutic disciplines. The patient population includes people with complex multisystem medical diseases, individuals with end stage renal disease and those with orthopedic conditions. ***Average LOS:*** 22.9 days ***Referral Process:*** • Completed HNHB LHIN Acute to Rehab and Complex Care (CCC) Referral Form sent via Fax. • Screeners (OT, PT & RN): Review referral and determine eligibility. ***Contact:*** Clinical Manager, 905-522-1155 ext. 33207. Fax: 905-540-6503	***Program Name:*** Convalescent Care Unit (CCU), St. Joseph's Villa. ***Location:*** 56 Governor's Road, Dundas, ON L9H 5G7 ***Number of Beds:*** 41 ***Program Description:*** The program is a unit for patients who no longer need hospital care, however are unable to return home as they need a period of time to regain full functional status and become once again independent with self-care. The majority of our patients are often recovering from medical or surgical acute care. The program includes a supportive team of 24 hour supervision with Nursing Care, Physiotherapy Services, Occupational Therapy Services, Social Work Services, Therapeutic Recreation programming and a selection of other supportive services. Convalescent Care is funded by the MOHLTC (90 days per calendar year) and patients must meet regulatory requirements. ***Objectives of the Program:*** • Timeframe for recovery of strength, endurance and functions • Patient participation in program activities and services • Health Teaching and capable of learning • Patient to return to home or transition to another bedded level of rehabilitative care ***Referral Process:*** Hospitals should fax a referral to the CCAC 905-639-6688. Community partners should telephone the CCAC at 1-866-790-4642 to request a referral. ***Contact:*** Program Lead, Manager SJV. 905-627-3541 ext 2350	**Program Name:** Complex Care (CC), St. Joseph's Healthcare Hamilton **Location:** 50 Charlton Ave. E. Hamilton, L8N 4A6 **Number of Beds**: 41 **Program Description:** The Complex Care program provides services to the following streams of CC patients: Medically Complex, Bariatric, and Dialysis. For these patients, the major portion of diagnostic tests must be completed and the patient must no longer require acute daily medical intervention by a physician. In addition, the patient must have completed the acute phase of their illness prior to application to the Complex Care program. (Contact program for additional information for specific streams: Medically Complex; Bariatric; Dialysis) **Referral Process:** Complete HNHB LHIN Acute to Rehab and Complex Care (CCC) Referral package & Regional Complex Care (CC) Program Letter of Understanding Fax referral to HNHB CCAC: 905-639-6688 ***Contact:*** Nurse Manager, Complex Care, SJHH, 905-522-1155, ext. 33788	**Program Name:** Complex Care (CC), St. Joseph's Healthcare Hamilton **Location:** 50 Charlton Ave. E. Hamilton, L8N 4A6 **Number of Beds**: 5 **Program Description:** The Complex Care program provides services to patients who require ventilator support. For these patients, the major portion of diagnostic tests must be completed and the patient must no longer require acute daily medical intervention by a physician. In addition, the patient must have completed the acute phase of their illness prior to application to the Complex Care program. (Contact program for additional information for specific streams: Ventilator Dependent) **Referral Process:** Complete HNHB LHIN Acute to Rehab and Complex Care (CCC) Referral package & Regional Complex Care (CC) Program Letter of Understanding Fax referral to HNHB CCAC: 905-639-6688 **Contact:** Nurse Manager, Complex Care, SJHH, 905-522-1155, ext. 3378

Hamilton Referral Options for Bedded Rehabilitative Care Programs/Services

☐ 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*:* Spinal Cord Injury Rehabilitation Program, Hamilton Health Sciences (HHS) **Location:** B2South, Regional Rehabilitation Center, 300 Wellington Street North, Hamilton, ON, L8L 0A4 **Number of Beds*:*** 13 **Program Description*:*** A program for adults (over 16 years), who have experienced a spinal cord injury (SCI) either due to a traumatic injury or non-traumatic illness (excluding cancer related causes). **Average LOS*:*** 55 Days **Referral Process:** Centralized Intake Process through HHS Intake Office. • Referral Form: HNHB LHIN Acute to Rehab and Complex Care (CCC) • Internal: Referral form submitted to Intake Office through Meditech • External: Referral Form sent via Fax • Refer to "Regional Rehabilitation Referral Process and Admission Criteria" **Contact:** HHS Rehab Intake Office P 905-521-2100 X 40806 F 905-521-2359	**Program Name:** Convalescent Care Program (CCP), Shalom Village **Location:** 70 Macklin Street North Hamilton, Ontario L8S 3S1 **Number of Beds:** 15 **Program Description:** The CCP was designed to help prepare people to return home after a hospital stay. The program focuses on helping participants rebuild strength, reduce their need for assistance, and reinforce their independence. The Shalom team works with participants to help them build strength and manage their daily activities. Participants wear their regular clothes and help prepare their own meals in the dining room. They participate in a variety of recreational and rehabilitative activities. They are active participants in their own recovery. The team works collaboratively with participants, their families, physicians and the Community Care Access Centre to help them regain strength, improve functioning and build confidence to ensure a smooth transition as they move back to their homes from our home. **Referral Process*:*** Hospitals should fax a referral to the CCAC 905-639-6688. Community partners should telephone the CCAC at 1-866-790-4642 to request a referral. **Contact Information**: Program Manager: 905-529-1613 ext. 267	***Program Name:*** Complex Care (CC), St. Peter's Hospital ***Location:*** 88 Maplewood Avenue, Hamilton L8M 1W9 (East 4 and West 4) ***Number of Beds****:* 63 in total ***Program Description*** have complex clinical needs that require comprehensive, interdisciplinary treatment, with goal to discharge to community setting. ***Referral Process:*** Complete HNHB LHIN Acute to Rehab and Complex Care (CCC) Referral package & Regional Complex Care (CC) Program Letter of Understanding Fax referral to HNHB CCAC: 905-639-6688 ***Contact:*** Clinical Manager, 905-537-0271 ext.12261	

☐ 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: Amputee Rehabilitation Program, Hamilton Health Sciences (HHS) **Location:** B2South, Regional Rehabilitation Center, 300 Wellington Street North, Hamilton, ON, L8L 0A4 **Number of Beds:** 3 **Program Description:** A program for adult with amputations to: Achieve ambulation; Practice functional ambulation activities; Practice functional activities of daily living; Have necessary equipment for discharge identified and prescribed. **Average LOS:** 4-6 Weeks **Referral Process:** Centralized Intake Process through HHS Intake Office. • Referral Form: HNHB LHIN Acute to Rehab and Complex Care (CCC) • Internal: Physician emails Intake Office – who create an inpatient referral form • External: Referral form faxed to HHS intake office • Refer to "Regional Rehabilitation Referral Process and Admission Criteria" **Contact:** HHS Rehab Intake Office P 905-521-2100 X 40806 F 905-521-2359	**Program Name**: Convalescent Care Program (CCP), Dundurn Place **Location:** 39 Mary St. Hamilton ON, L8R 3L8 **Number of Beds**: 28 **Program Description**: The program is designed around "Bridge to Home", when patients are no longer acute and need to be cared for in a hospital setting but need more time to regain full functional status in terms of self-care to return to independent living in the community. The Restorative program ensures patients are able to dress themselves, prepare simple meals and cope with strategies to overcome limitations. The program includes a multidisciplinary team. **Our Goal**: To ensure we support all individual care needs, promote independence and encourage every patient to achieve their goal(s) prior to returning to their homes. Our specialized Health Care Team will ensure their short term stay of all patients is pleasant, productive and educational. **Referral Process:** Hospitals should fax a referral to the CCAC 905-639-6688. Community partners should telephone the CCAC at 1-866-790-4642 to request a referral. **Contact:** Program Manager,905-523-6427 ext 211		

☐ 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: Stroke Rehabilitation Program, Hamilton Health Sciences (HHS) **Location:** B2North, Regional Rehabilitation Center, 300 Wellington Street North, Hamilton, ON, L8L 0A4 **Number of Beds**: 28 **Program Description:** A program emphasizing education and functional retraining to help patients who have experienced a stroke and their families manage independently upon discharge. **Average LOS:** 29 Days **Referral Process:** • Integrated Stroke Program with no formal intake process. From their acute phase of care, patients flow to their next appropriate phase of recovery by day 3-5 post stroke. The Integrated Stroke Navigator facilitates these processes including the flow to active rehab. • External: Stroke Navigator receives a phone call requesting an inpatient rehab admission from hospital and community partners. These cases are reviewed by the stroke physiatrist for decision. ***Contact:*** Integrated Stroke Program Navigator 905-521-2100 X 46488 289-439-5624 Cell			

☒ 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: ABI Rehabilitation Program – Neurobehavioural Program, Hamilton Health Sciences (HHS) **Location:** B3North, Regional Rehabilitation Center, 300 Wellington Street North, Hamilton, ON, L8L 0A4 **Number of Beds**: 12 **Program Description:** A program for adults with combined ABI and mental health impairments who display challenging, responsive behaviours that prevent them from living successfully in the community without ongoing supports. The program provides a structured environment to achieve behavioural self-regulation that can be used in a community environment. **Average LOS:** 144 Days **Referral Process:** Centralized Intake Process through HHS Intake Office. • Referral Form: HNHB LHIN Acute to Rehab and Complex Care (CCC) • Internal: Referral form submitted to Intake Office through Meditech • External: Referral form Faxed to HHS intake office **Contact:** HHS Rehab Intake Office P 905-521-2100 X 40806 F 905-521-2359			

☐ 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: ABI Rehabilitation – Slow to Recover & Community Re-Integration Programs, Hamilton Health Sciences (HHS) **Location:** B3South, Regional Rehabilitation Center, 300 Wellington Street North, Hamilton, ON, L8L 0A4 **Number of Beds**: 18: 6 Slow to Recover & 12 Community Re-Integration **Program Description:** **Community Re-Integration:** A program for adults (over 16 years) with an acquired brain injury to develop a level of independence sufficient for re-integration into the community. Functional life skills training are provided for individuals with moderate acquired brain injuries and are designed with regard to the discharge environment **Slow to Recover:** A program for adults (over 16years) with severe brain injury who may be intermittently or minimally responsive, have significant physical need and need for regular nursing intervention. The program focus is increased function and quality of life. **Average LOS:** 62 Days **Referral Process:** Centralized Intake Process through HHS Intake Office • Referral Form: HNHB LHIN Acute to Rehab and Complex Care (CCC) • Internal: Referral form submitted to Intake Office through Meditech • External: Referral form Faxed to HHS Intake office •Refer to "Regional Rehabilitation Referral Process and Admission Criteria" **Contact:** HHS Rehab Intake Office P 905-521-2100 X 40806 F 905-521-2359			

☐ 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: Musculoskeletal Rehabilitation Program, Hamilton Health Sciences (HHS) **Location:** M2, Juravinski Hospital, 711 Concession St, Hamilton, ON L8V 1C1 **Number of Beds***: 2*3 **Program Description:** A program for those who have sustained a fractured hip, or undergone arthroplasty surgery and whose needs, following the acute phase of treatment, cannot be met in the community. Patients are active participants in their rehabilitation program which includes therapy sessions, and practicing skills on the unit and in other environments to prepare for discharge home. **Average LOS:** 21 days **Referral Process:** Centralized Intake Process through HHS Intake Office • Referral Form: HNHB LHIN Acute to Rehab and Complex Care (CCC) • Internal: Referral form submitted to Intake Office through Meditech • External: Referral form Faxed to HHS Intake office. • Refer to "Regional Rehabilitation Referral Process and Admission Criteria" **Contact:** HHS Rehab Intake Office P 905-521-2100 X 40806 F 905-521-2359			

☐ 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: Oncology Rehabilitation Program, Hamilton Health Sciences (HHS) **Location:** M2, Juravinski Hospital, 711 Concession St, Hamilton, ON L8V 1C1 **Number of Beds**: 4 **Program Description:** A program for people with cancer who are undergoing cancer treatment to exercise and strengthen in order to return home **Average LOS:** 21 days **Referral Process:** Centralized Intake Process through HHS Intake Office • Referral Form: HNHB LHIN Acute to Rehab and Complex Care (CCC) • Internal: Referral form submitted to Intake Office through Meditech External: Referral form Faxed to HHS Intake office. • Refer to "Regional Rehabilitation Referral Process and Admission Criteria" **Contact:** HHS Rehab Intake Office P 905-521-2100 X 40806 F 905-521-2359			

☐ 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: Geriatric Rehabilitation Program, Hamilton Health Sciences (HHS) **Location:** M3, Juravinski Hospital, 711 Concession St, Hamilton, ON L8V 1C1 **Number of Beds:** 18 **Program Description:** A program for those who require a comprehensive geriatric assessment. Patients are active participants in their rehabilitation program which includes therapy sessions, and practicing skills on the unit (e.g. self-medication, self-catheterization). **Average LOS:** 20 days **Referral Process:** Centralized Intake Process through HHS Intake Office • Referral Form: HNHB LHIN Acute to Rehab and Complex Care (CCC) • Internal: Referral form submitted to Intake Office through Meditech • External: Referral form Faxed to HHS Intake office. • Refer to "Regional Rehabilitation Referral Process and Admission Criteria" ***Contact:*** HHS Rehab Intake Office P 905-521-2100 X 40806 F 905-521-2359			

Hamilton Referral Options for Bedded Rehabilitative Care Programs/Services

☐ 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: Complex Care (CC), Rehabilitation, low intensity, St. Peter's Hospital, Hamilton Health Sciences (HHS) ***Location:*** 88 Maplewood Avenue, Hamilton L8M 1W9 (2 West) ***Number of Beds****:* 44 ***Program Description:*** 45- 60 days of active rehabilitation therapy, for patients who need assistance to overcome the effects of serious health challenges, with goal of discharge home ***Referral Process:*** Complete HNHB LHIN Acute to Rehab and Complex Care (CCC) Referral package & Regional Complex Care (CC) Program Letter of Understanding Fax referral to HNHB CCAC: 905-639-6688 ***Contact:*** Clinical Manager, 905-537-0271 ext. 12524			

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.