Ontario
Waterloo Wellington Local Health Integration Network

Waterloo Wellington Rehabilitative Care Framework (Bedded Levels)

Rehabilitative Care for medically stable patients who do not require 24 hour nursing or medical care will be supported in the community. If daily therapy is required, consider the Rapid Recovery Therapy Program in lieu of the Rehabilitation bedded level of rehabilitative care.

Eligibility Criteria for Bedded Levels of Rehabilitative Care (Provincial Rehabilitative Care Alliance)

1. 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);

2. The patient/team has goals that are specific, measurable, realistic and timely (SMART).
   - Goals should be connected to a realistic discharge plan (e.g. previous living arrangement such as: home, RH, supervised living, independent living) that has been discussed with the patient/client at the referring site.

3. The patient/client is **able to participate in** and benefit from rehabilitative care within the context of his/her specific functional goals, at the intensity of the level of rehabilitative care selected;
   - has 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.
   - has sufficient cognitive ability and the physical tolerance to participate in and progress during rehabilitative care (although the patient's initial functional tolerance may fluctuate). Patient may require cueing and repetition, but demonstrates some functional improvement.
   - other comorbid illnesses will not interfere with the individual's ability to actively participate in the program on a daily basis (for example, ongoing treatment which will require frequent trips off site and may impact activity tolerance)

4. The patient's/client's goals/care needs cannot otherwise be met in the community.

5. 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; co-morbidities have been established
   - There are no unaddressed medical issues (e.g. excessive shortness of breath, congestive heart failure, abnormal vital signs)
   - All consults and diagnostic tests for the purposes of diagnosis or treatment of acute conditions have been completed and reported or pending test results are not anticipated to dramatically change the treatment plan.
   - All abnormal lab values have been acknowledged and addressed as needed
   - Medication needs have been determined
   - 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.
     A follow-up plan is in place at the time of the referral and follow-up appointments have been made at the time of discharge from the acute hospital.

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<table>
<tr><th></th><th colspan="2">Rehabilitation</th><th>Activation/Restoration</th><th>Complex Medical Management
(Short Term and Long Term)</th></tr>
<tr><th></th><th>General Rehabilitation and Stroke Rehabilitation</th><th>Low Intensity Rehabilitation
(currently Restorative Care)</th><th></th><th></th></tr>
<tr><td>Focus of Program</td><td colspan="2"><u>Progression</u>
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.</td><td><u>Progression</u>
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.

Includes nursing rehabilitation, a community dining room, and opportunities for socialization.</td><td><u>Short Term: Stabilization & Progression</u>
Medically complex and specialized services to avoid further loss of function, increase activity tolerance and progress patient.

<u>Long Term: Maintenance</u>
Medically complex and specialized services over an extended period of time to maintain/slow the rate of, or avoid further loss of, function</td></tr>
<tr><td>Patient Populations</td><td colspan="2">Medically stable, able to participate in comprehensive rehabilitation program

*Stroke patients should be referred to Stroke Rehab only</td><td>Medically stable, cognitively and physically able to participate in restorative activities</td><td>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.

Long Term: Medically complex with long-term illnesses/disabilities, requiring on-going medical/nursing support that cannot be met at home or in a LTCH</td></tr>
<tr><td>Therapy Intensity</td><td>15-30 min of therapy 3x/day up to 3 hrs/day, up to 7 days per week. (Able to participate in frequent intervals of therapy totaling a minimum of 60 min per day).

Requires frequent/daily re-assessment by regulated health professionals.

Able to tolerate being up in a chair 1-2 hr, 2-3 times per day.

<table><tr><th></th><th>CMH</th><th>FP</th><th>SJ</th></tr><tr><td>OT
PT</td><td>1:14</td><td>1:8</td><td>1:11</td></tr><tr><td>OTA
PTA</td><td>1:7</td><td>1:1
1</td><td>1:11</td></tr></table></td><td>15-30 minutes 3 times per day up to 7 days per week (minimum total of 45 minutes)

Patients can be referred to General Rehab (same site recommended) as their tolerance increases.

Able to tolerate being up in a chair 1-2 hr, 1-2 times per day.

<table><tr><th></th><th>FHC</th><th>SJ</th></tr><tr><td>OT
PT</td><td>1:20</td><td>1:25</td></tr><tr><td>OTA
PTA</td><td>1:15</td><td>1:17</td></tr></table></td><td>Consultation by regulated health professionals, delivered mostly by non-regulated professionals as assigned (in Waterloo Wellington, 50% PT, 50% PTA).

Restorative activities may be provided in a group or 1:1 setting, throughout the day for 30 mins up to 2 hrs/day (5-7 days/week). Primarily physiotherapy.

<table><tr><th></th><th>SSCC</th><th>GMCH</th></tr><tr><td>PT</td><td>1:36</td><td>1:30</td></tr><tr><td>PTA</td><td>1:27</td><td>1:30</td></tr><tr><td>OT</td><td>1:134</td><td>0 contracted if needed</td></tr></table></td><td>Short Term: Up to 1 hr, as tolerated by the patient

Regulated health professionals to maintain/maximize cognitive, physical, emotional, functional abilities. Supported by non-regulated health professionals as assigned.

Long Term: Regulated health professional available to maintain and optimize functional abilities.

<table><tr><th></th><th>FP</th><th>GMCH</th><th>SJ</th></tr><tr><td>OT</td><td>1:68</td><td>0</td><td>1:110</td></tr><tr><td>PT</td><td>1:103</td><td>1:30 *incl Activation</td><td>1:110</td></tr><tr><td>OTA
PTA</td><td>1:41</td><td>1:30 *incl Activation</td><td>1:59</td></tr></table>
Ratio includes palliative care beds at all sites</td></tr>
</table>

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	Rehabilitation		Activation/Restoration	Complex Medical Management (Short Term and Long Term)
	General Rehabilitation and Stroke Rehabilitation	**Low Intensity Rehabilitation (currently Restorative Care)**		
Nursing Care	Typically Up to 3 hours per day. Some patients may require up to 4 hours per day.		< 2 hours per day (WW 2-3 hr/day) PSW, RPN, RN	> 3 hours per day
Medical Care	Daily physician or nurse practitioner access		Weekly physician access/follow-up	Access to scheduled physician care/daily medical oversight
Length of Stay	The Average LOS is expected to range between 7 and 40 days.	Up to 90 days. Often around 40 days.	Up to 90 days.	Short Term: Up to 90 days.
Discharge Indicator	**Rehab goals met and/or functional plateau, access to MD/nursing care no longer required**			Short Term: Medical/functional recovery to allow patient to safely transition to next level of rehab care or alternate environment Long Term: Patient is designated to be more or less a permanent resident in the hospital and will remain until medical/functional status changes
Locations	CMH, SJHCG, GRH-Freeport	SJHCG, GRH-Freeport	Sunnyside Convalescent Care Program, Groves	SJHCG, GRH-Freeport, Groves
Application	• Provincial Referral Form • Letter of Understanding WW553D,E • Change of Status (if applicable) WW551B • Medical Stability and Program Readiness WW551A		• Provincial Referral Form • Letter of Understanding WW553F • Change of Status (if applicable) WW551B • Medical Stability and Program Readiness WW551A	• Provincial Referral Form • Letter of Understanding 553A,B • Change of Status (if applicable) WW551B • Medical Stability and Program Readiness WW551A

A Decision Making Tree for the need for a bedded level of rehabilitative care (does not include Rapid Recovery Therapy Program) can be found at http://www.rehabcarealliance.ca/uploads/File/Toolbox/Definitions/Referral_Decision_Tree_for_Rehabilitative_Care_FINAL__Dec_11_2014_.pdf

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.