GTA REHAB Network

Referral Guideline for Bedded Levels of Rehabilitative Care

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Introduction

The guidelines within this document are an updated version of the *Inpatient Rehab Referral Guidelines* (2009). The guidelines have been revised to align with the provincial Definitions Framework for Bedded Levels of Rehabilitative Care, developed by the Rehabilitative Care Alliance. These guidelines are intended for general application across multiple rehab populations in need of a bedded (inpatient) level of rehabilitative care.

There are 4 bedded levels of rehabilitative care:

- Rehabilitation: (functional goal = progression)
  - High intensity
  - Low intensity
- Activation/Restoration (functional goal = progression)
- Short Term Complex Medical Management (functional goal = stabilization and progression)
- Long Term Complex Medical Management (functional goal = maintenance)

See Appendix A for key features of each of the bedded levels of rehabilitative care. For a more detailed description of each of the levels, see Definitions Framework for Bedded Levels of Rehabilitative Care.

To optimize the referral process, these guidelines are organized around patient-specific criteria related to the determination of patients eligible for rehabilitative care, their medical stability and readiness for rehab.

The benefits of these guidelines are to:

- ensure that rehab referrals are submitted in a timely and appropriate manner
- minimize the number of days that patients are designated as Alternate Level of Care (ALC).

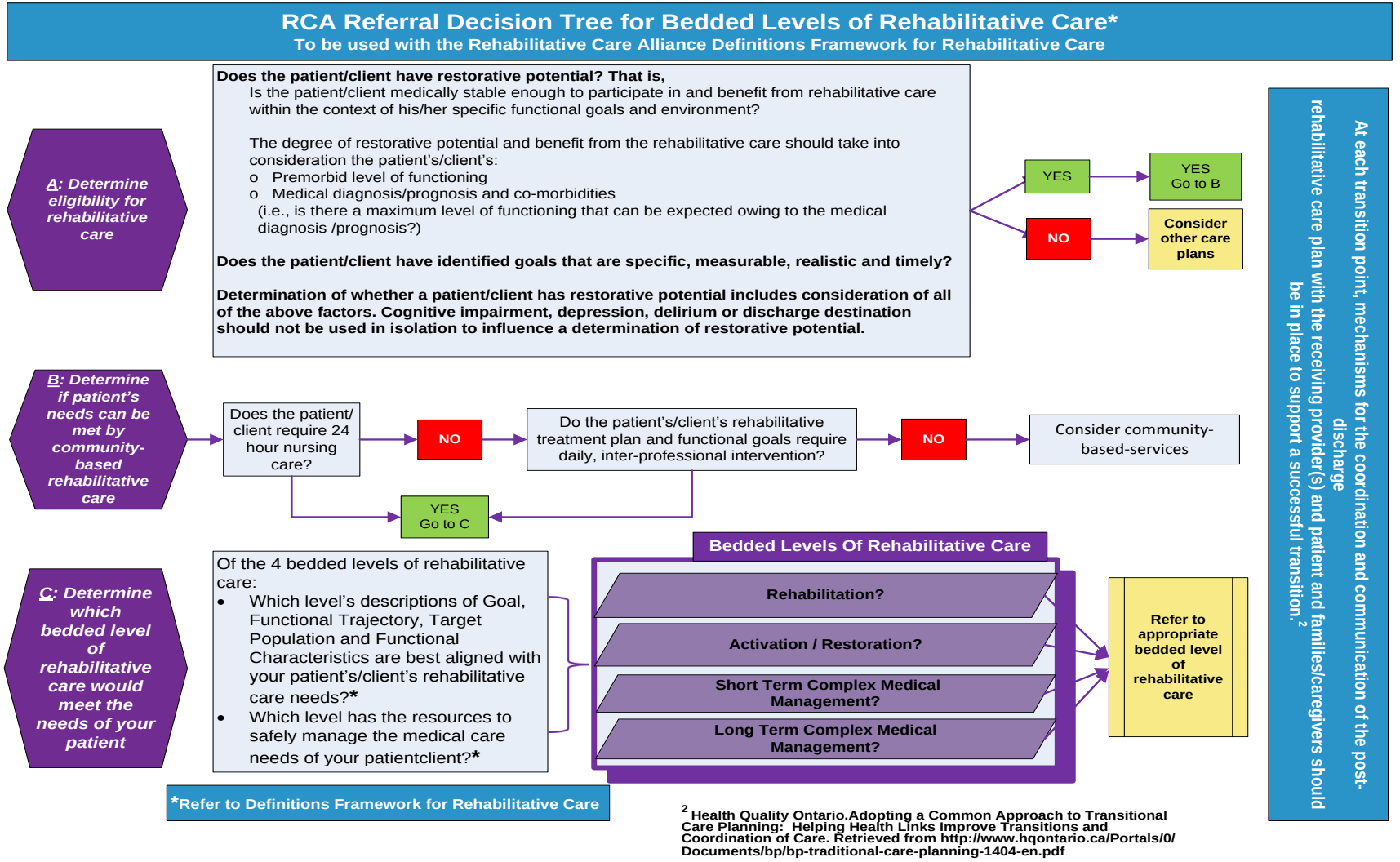
Application of **each and every component** of these guidelines should result in the timely submission of rehab referrals, preferably **at or before** ALC designation*. Approaches should be in keeping with Access to Care, Alternate Level of Care Leading Practices User Guide.[1]

*Further information regarding ALC designation can be found in Appendix B.

Recognizing that each rehab program has its own set of admission criteria, **these guidelines are to be considered in their entirety** and **used in conjunction with the specified admission criteria of individual inpatient rehabilitative care programs.**

[1]Alternate Level of Care Leading Practices User Guide. Access to Care, CCO 2017.

Detailed information about the admission criteria of individual rehab programs can be found using the admission information tool, ***Rehab Finder***, available on the GTA Rehab Network website (see: www.gtarehabfinder.ca)



*This referral decision tree was developed by the Rehabilitative Care Alliance.

Referral Guidelines

DETERMINING ELIGIBILITY FOR REHABILITATIVE CARE[2]…

✓ **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).

***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.

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.

[2] Rehabilitative Care Alliance. Definitions Framework for Bedded Levels of Rehabilitative Care. 2017

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.

DETERMINING REHAB READINESS …

- ✓ Patient has restorative potential as defined in guideline above.
- ✓ Patient meets the criteria of medical stability as defined in guideline above.
- ✓ All medical investigations have been completed ***or*** a follow-up plan is in place at time of referral and follow-up appointments made by time of discharge.
- ✓ Patient's special needs have been determined.
- ✓ Patient is able to meet the minimum tolerance level of the rehab program as defined by its admission criteria.
- ✓ There are no behavioural issues limiting the patient's ability to participate at the minimum level required by the rehab program.
- ✓ There are no psychiatric issues limiting the patient's ability to participate at the minimum level required by the rehab program.
- ✓ Treatment for other co-morbid illnesses/conditions does not interfere with the patient's ability to participate in rehab (e.g. dialysis or active cancer treatment).
- ✓ Patient's discharge options following rehab have been discussed.

DETERMINING TIMING OF SUBMISSION OF APPLICATION FOR REHAB …

- ✓ Patient meets the eligibility criteria rehabilitative care e as defined in the guideline above.
- ✓ Patient meets the criteria of medical stability as defined in the guideline above ***or*** patient's date of medical stability can be identified within the next 1-2 days of submission of application.
- ✓ Patient meets the criteria for rehab readiness as defined in the guideline above ***or*** the date for rehab readiness can be identified.

Note I: Once it is determined that a patient is eligible for rehabilitative care, medically stable and the date of rehab readiness is known, the referral to rehab should be submitted. Planning for discharge should begin prior to ALC designation.

Note II: Referrers should notify rehab facilities of the cancellation of the referral in the event that the referral is no longer required.

DETERMINING NUMBER OF REFERRALS TO BE SUBMITTED …

✓ Organizations should send referrals to a minimum of 3 rehab programs as appropriate.[3]

Detailed information about the admission criteria of individual rehab programs can be found using the admission information tool, ***Rehab Finder***, available on the GTA Rehab Network website (see: www.gtarehabfinder.ca).

This web-based resource provides comprehensive information on all publicly-funded and fee-for-service rehab programs/services provided by hospitals and Home and Community Care that are members of the GTA Rehab Network.

DETERMINING TIMING OF AND RESPONSE TO REFERRALS …

✓ Responses to referrals should be given within 2 business days of receipt of application.

✓ Responses to referrals should be specific to one of the following response categories:

Referral Accepted. (Provide estimated date of admission). Patient could be on a waitlist for a bed for the following reasons:

- Current bed availability
- Current resource availability to accommodate complex patient needs
- Infection control issues

Referral Redirected to another program within the organization**.** (Provide name of program.):

- wrong level of care selected for patient's needs

Request for Information due to**:**

- referral form is incomplete
- information is insufficient/inconsistent to make a decision regarding rehab readiness
- patient's current status does not indicate rehab readiness. Update required.

[3] Please note that a minimum of 3 applications may not be required in hospitals with internal rehab beds (as per organization-specific policies) or for some specialized rehab programs.

Referral Denied because:

- patient does not meet program criteria/requirements
- patient needs a secured unit
- program cannot accommodate medical needs
- program cannot accommodate behavioural issues
- program cannot accommodate psychiatric issues

Referral Cancelled:

- patient and/or clinician decided the specified location was not appropriate

Appendix A:
The table below highlights the key features of the bedded levels of rehabilitative care to help you determine which level best meets the rehabilitative care needs of patients. 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.

Appendix B

Provincial Alternate Level of Care (ALC) Definition For implementation in all acute and post-acute hospitals*
(Adapted from the Wait Time Information Strategy)

Provincial ALC Definition
The healthcare system aspires to deliver care in a setting that is congruent with the clinical needs of a patient as defined by the patient's health status, treatment plan and goals.

The definition applies to all patient populations waiting in all patient care beds in an acute or post acute care hospital in Ontario.

Definition:
When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC)[1] at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination[2] (or when the patient's needs or condition changes and the designation of ALC no longer applies).

*as of July 1, 2009

Note 1
The patient's care goals have been met ***or***
- progress has reached a plateau ***or***
- the patient has reached her/his potential in that program/level of care ***or***
- an admission occurs for supportive care because the services are not accessible in the community (e.g. "social admission").

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

Note 2
Discharge/transfer destinations may include, but are not limited to:
- home (with/without services/programs),
- rehabilitation (facility/bed, internal or external),
- complex continuing care (facility/bed, internal or external),
- transitional care bed (internal or external),
- long term care home,
- group home,
- convalescent care beds,
- palliative care beds,
- retirement home,
- shelter,
- supportive housing.

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

Final Note
The definition **does not** apply to patients:
- waiting at home,
- waiting in an acute care bed /service for another acute care bed/service (e.g., surgical bed to a medical bed),
- waiting in a tertiary acute care hospital bed for transfer to a non tertiary acute care hospital bed (e.g., repatriation to community hospital).