

REHAB DEFINITIONS INITIATIVE

FINAL REPORT

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1.0 Executive Summary

Since 2006, the GTA Rehab Network has been leading a large-scale initiative to develop standardized rehabilitation program definitions for publicly-funded rehabilitation services across the care continuum. This initiative has translated evidence-based best practices into population-specific rehab frameworks to define the “gold standard” for what should occur as leading practices within rehab programs across the continuum. In the absence of evidence-based literature, definitions have been derived through consensus on optimal clinical practices. In addition to the rehabilitation frameworks, self-assessment tools have been developed to support organizations in the evaluation of their rehab programs against the definitions in each framework.

Through this process, the Network has engaged a large number of representatives from a variety of clinical backgrounds including physicians, nurses, occupational therapists, physiotherapists, speech language pathologists and others from across the continuum and across the Greater Toronto Area (and provincially in some cases) (See Appendix A for list of committee members).

A consistent and deliberate process has been used to reference existing best practice guidelines where available and engage with other networks/organizations to leverage collaborations and avoid duplication of effort. As evidence and models of practice continue to evolve, maintaining the definitions frameworks for each population will be an ongoing, iterative process.

Rehab frameworks and self-assessment surveys have been completed for the following populations: Geriatric, Stroke, ABI/Neuro, Spinal Cord Injury, Oncology, Amputee and Pulmonary rehab. Findings from these self-assessment surveys indicate that many of the programs across rehab population groups were unable to meet designated key criteria. Rehab definition frameworks have been completed for Cardiac, Burns and MSK/Trauma rehab and the self-assessment surveys were disseminated in March 2010.

The Rehab Definitions Initiative has the endorsement of the Network’s Coordinating Council as an important step towards:

- Defining and promoting consistency in rehab care across different care settings through the translation of evidence into population-specific rehab definition frameworks
- Enhancing transparency in rehab programming across organizations and optimizing the appropriate matching of rehab needs
- Evaluating rehab performance against the definitions in the frameworks and using the self-assessment findings to identify opportunities for quality improvement and inform planning

An important next step, following the completion of all of the population-specific rehab definitions, will be the development of a set of performance indicators and benchmarks for use by rehab programs¹. The identification of performance indicators and benchmarks will be based on their (1) relevance to rehabilitation, clinical outcomes and administrative processes (e.g. wait times); and (2) their alignment with the rehab definition frameworks across rehabilitation sectors (e.g. inpatient rehab, outpatient rehabilitation). The Network has submitted preliminary considerations for the development of such indicators and benchmarks to the Toronto Central LHIN in its December 2009 report, System Performance Indicators for Rehabilitation and Complex Continuing Care.

Next steps include

- reviewing and updating the rehab frameworks to ensure they are consistent with emerging evidence and current models of practice;
- investigating the requirements for modifying Rehab Finder to enable it to incorporate self-assessment findings as a basis for streamlining and organizing its listing of rehab programs;
- sharing key learnings from the initiative with stakeholders

¹ The development of performance indicators for rehabilitation was recommended and strongly endorsed by members at the GTA Rehab Network’s Strategic Planning Session, held on June 1, 2009.

- using the evidence and learnings from this initiative as a basis to inform system-wide discussions on the organization and delivery of rehabilitation services to support improvements in patient flow and clinical outcomes.

The Network's definitions initiative has generated interest from across the province. The Network has been asked to present on this initiative twice to the OHA Rehab/CCC Leadership Council and as rehabilitation networks evolve in other regions across the province, comparable initiatives to define rehabilitation programs have been outlined in their work plans. In addition to receiving funding from the Toronto Central LHIN in 2009 to support the Network's Definition initiative, this work has also been referenced by reports for the LHINs including the Rehabilitation Task Group of the Central East LHIN (March 2009 report); and the Rehabilitation / Alternate Level of Care Capacity Assessment conducted by the Central LHIN in March 2009. The Network has also been part of LHIN consultations on related initiatives and was consulted in 2009 by the Mississauga Halton LHIN in their review of post acute programs and most recently, the Network has been asked to participate in the development of a rehabilitation framework to be completed by the Central West LHIN.

In addition to the learnings from engaging in a review of rehabilitation programs for each population, a unique and added value of this initiative stems from the Network's collective review across populations, which has illustrated gaps in service across population specific programs and highlighted differences in flow and use of alternate models.

The Rehab Definitions initiative serves as not only a quality improvement tool for organizations to compare performance of their programs against evidence-based frameworks, but it is expected that the GTA Rehab Network and others will use the work of the rehab definitions initiative as a basis to inform discussions on capacity planning including review of access and flow of individuals across health services.

2.0 Background

The GTA Rehab Network's Rehab Definitions Initiative was prompted by the need to address the confusion about the variations in service scope among rehab programs, including those that serve the same client populations. The Network recognized that standards in rehabilitation programming, including clear definitions about the services provided, would promote consistency in rehab care and provide clarity for patients, families and referrers. Although some related work was done previously by the Ontario Hospital Association to classify rehab population groups, the definitions were broad and provided little direction to guide rehab programming. As a result, rehab programs have varied in terms of what they provide making it difficult to compare potential rehab options at the point of referral. Such differences among rehab programs have also reduced the capacity for effective system planning and performance measurement.

3.0 Approach

3.1 *Phase 1: Rehab Conceptual Framework*

The first phase of the initiative was conducted in the spring of 2006. The Network brought together representatives from across the continuum including stakeholders from acute care and rehab hospitals, the University of Toronto, Community Care Access Centres and long-term care to develop a conceptual rehab framework outlining the core elements of rehabilitation in institutional and community-based settings. Guiding principles to inform the initiative were identified such that the rehab frameworks:

- Utilize the World Health Organization's definition of rehabilitation
- Refer to publicly-funded cognitive & physical forms of rehab for clients with rehab potential and defined goals
- Provide definitions for each rehab sector based on the ideal or "gold standard" of practice using evidence where available
- Describe categories based on rehab needs and typical services provided – not length of stay or type of rehab bed
- Are validated through input from stakeholders and content experts

The conceptual rehab framework addresses rehab services that are provided in the acute care setting, the inpatient setting and in the community setting and for each of these settings, the services, differential criteria, degree of specialization and key activities of rehabilitation were delineated. [See Appendix B] Following its development, the conceptual framework was presented to and approved by a large constituency of health providers involved in rehabilitation in June 2006.

3.2 *Phase 2: Population-Specific Frameworks*

The second phase of the initiative began in the fall of 2006 and focused on the development of population-specific rehab frameworks. The rehab conceptual framework provided the foundation from which the individual rehab population frameworks were developed. Using evidence-based best practices or, in the absence of evidence in the literature, consensus on optimal clinical practices, the goal of the initiative was to develop the ideal or "gold standard" of practice.

Population-specific task groups, comprised of clinical/content experts from acute care and rehab hospitals within the GTA and in some cases from across the province, were convened as frameworks were developed. Task group members reviewed best practices, current research and clinical practices. In addition, a number of "trigger" questions generated further points for discussion. These included the following:

- a. Is it appropriate for the rehab population to be mixed with other rehab groups on a unit and if so, which ones?
- b. What criteria can be used to assist in identifying the patient's primary rehab needs for triage to the most appropriate rehab program?
- c. What level of specialization is needed at each phase of the continuum? What services should be regional and more specialized versus those that can be provided within local communities closer to home?
- d. What patient volume is required to sustain an adequate critical mass to support the development and maintenance of clinical expertise?

Population-specific rehab frameworks are now available for 12 rehab population groups: Stroke, Geriatric, ABI/Neuro, Spinal Cord Injury, Oncology, Cardiac, Burns, Amputee, Pulmonary Rehab and MSK/Trauma Rehab.

3.3 Phase 3: Self-Assessment

Once the first set of rehab frameworks were developed, it became clear that a resource tool was needed to help member organizations make practical use of the frameworks by assessing how well their programs met the rehab definitions and criteria. Self-assessment tools for acute care, inpatient rehab, outpatient/ambulatory rehab and community-based rehab have been developed to accompany the rehab frameworks for each population.

Organizations use the self-assessment tool to determine if their programs “fully meet” the criteria (i.e. meet the criteria \geq 80% of the time); “partially meet” the criteria (i.e. 40 – 79% of the time); or “do not meet” the criteria (i.e. criteria are met $<$ 40% of the time). While individual programs make use of the survey findings to improve the delivery of rehab services within their own organization, the GTA Rehab Network analyzes the survey findings to determine how well, on a systems-wide level, programs meet all of the criteria and how well individual programs are able to meet designated key criteria² from the population-specific framework.

The self-assessment tools, as new resources, provide a mechanism through which the GTA Rehab Network and individual member organizations can assess what is currently provided in rehabilitation programs/services against the evidence-based definitions in the rehab frameworks. The self-assessment findings provide the basis for identifying opportunities for quality improvement initiatives to support patient flow and quality rehab care. They also provide the Network with information to help target its initiatives and assist member organizations in working towards the gold standards outlined in the rehab program definitions. From a system-planning perspective, the Network can use the aggregated findings to conduct a system-wide analysis of rehab programming, rehab resources, and issues related to access to support capacity planning across the rehabilitation sector.

Finally, the self-assessment findings will also be used in future to describe the rehab programs offered by member organizations on the Network’s Rehab Finder, its web-based, searchable listing of rehab programs, to provide increased transparency about the quality of programs offered and further clarity for referrers and patients and families about available rehab options.

4.0 Key Findings from the Population-Specific Rehab Definitions Frameworks

4.1 Geriatric/Medically Complex Rehab

Geriatric rehab was identified as an initial area of focus for the Rehab Definitions Initiative in response to the Network’s 2006 ALC survey findings and feedback from its 2006 consultation session. The ALC survey found that 43% of ALC patients awaiting rehab had been referred for geriatric rehab and accounted for the largest total number of ALC days (365 days). In addition, stakeholder feedback indicated that referrers experienced much confusion about where to refer elderly patients for rehab since many rehab programs include seniors in their admission criteria.

To address the complexities involved in providing clear rehab definitions for seniors requiring rehabilitation, an extensive literature review and key informant interviews with geriatricians from around the province were conducted to obtain consensus on the terms geriatric, frail and medically complex within the senior population in the fall of 2006. Findings from these activities³ were used by the Geriatric Rehab Definitions Task Group to develop standardized definitions to describe the staffing, services offered and differential criteria for geriatric rehab using evidence-based best practices. A new triage

² Key criteria, representing approximately half of all the criteria in a population-specific framework, are selected by the task group that developed the rehab framework following the self-assessment phase. An expectation has been set that rehab programs meet, at a minimum, all of the key criteria.

³ A summary of these discussions and findings can be found in the GTA Rehab Network report, Clarifying the Complexities of Inpatient Geriatric Rehab (February 2007). The report can be downloaded from the GTA Rehab Network website at <http://www.gtarehabnetwork.ca/pubreport.asp>.

guideline for inpatient geriatric rehab was also developed and piloted in the winter of 2007 to assist referrers in referral decision-making. The tool triages senior rehab patients based on rehab potential and rehab readiness; the primary focus of rehab (e.g. impaired premorbid functioning and current multi-system needs vs. functional impairment arising from recent acute event); and the patient's rehab tolerance level.

Self-assessments were conducted by acute care, rehab hospitals and community care access centres in the winter of 2008. A total of 40 surveys were received from rehab programs spanning acute care, inpatient and outpatient/ambulatory, and community settings. An analysis of the surveys highlighted the following key findings:

- Acute Care:
 - All specialized geriatric units in acute care met all of the key criteria; however, greater expertise among staff in the care of the elderly on non-specialized geriatric units with high number of seniors is recommended (i.e. General Internal Medicine) with increased access to geriatric consult teams on medical units.
- Inpatient Rehab:
 - While the dedicated geriatric rehab programs were able to meet most of the key criteria, all programs needed to improve their provision of wellness education to patients. (Of note, some organizations indicated that the self-assessment survey prompted them to implement wellness focussed education into their programs.)
 - Mixed population rehab programs, where many elderly patients are seen, need to increase their specialization in multi-system issues and principles of senior-focused care. This would include maintaining a critical mass of 8 beds with clustered beds/teams to support the development of expertise in senior-focused care.
 - The Low Tolerance Long Duration (LTLTD) programs performed quite well with respect to meeting the key criteria and providing access to the recommended core team members, including a physician with expertise in medical complexity and senior-focused care principles.
- Outpatient and Community-Based Rehab:
 - Outpatient/ambulatory rehab programs performed well with respect to the criteria for services provided and specialization; however, increased access to the recommended core team members on a dedicated basis is needed (i.e. access to a clinical dietician, pharmacist, therapeutic recreation therapists, chaplain, and speech-language pathologist).

The development of the Geriatric Rehab Definitions Framework, undertaken within a broader context of obtaining an enhanced understanding of the diverse patient profiles and rehab needs among the senior rehab population, presented many challenges. Data from 2005 indicates that seniors over the age of 65 represent approximately 71% of all inpatient rehabilitation patients and of these, almost half (47%) are over 74 years of age.⁴ These seniors do not represent a homogenous group with respect to their rehab needs and therefore they are referred to a variety of inpatient rehab programs. Developing a triage tool to help determine which elderly rehab patients require a specialized geriatric rehab program versus a rehab program dedicated to a particular diagnostic rehab group (e.g. ABI, Stroke, MSK) versus a mixed population rehab program required much discussion and multiple revisions to the triage tool, particularly as task group members struggled to understand which services are currently provided and which ought to be provided in each of these types of programs.

4.2 Stroke Rehab

The Stroke Rehab Definitions Framework was developed in the winter of 2007 with input from acute care and rehabilitation hospitals and community care access centres. Other task group participants included the four rehab/education coordinators from the Toronto area regional stroke networks as well as the

⁴ Canadian Institute for Health Information. Inpatient Rehabilitation in Canada, 2003-2004. Special Topic: A Look at the Older Population. (2005)

consultant/project lead from the Heart and Stroke Foundation of Ontario (HSFO) involved in the development of the Ontario Stroke System's Rehab Consensus Panel Standards.

In an effort to reduce duplication of efforts and reduce the burden on stroke rehab providers involved in the completion of self-assessment surveys, the GTA Rehab Network subsequently collaborated with the Toronto area regional stroke managers and rehab coordinators to develop a self-assessment survey that would serve a dual purpose: to assess stroke programs against the newly developed Ontario Stroke System's Rehab Consensus Panel standards and assess them against the GTA Rehab Network's Stroke Rehab Definitions Framework. The self-assessment surveys were disseminated by the Regional Stroke Managers of the West GTA, Toronto West, South East and North and East regions in January 2008. The regional stroke networks shared their data with the Network for an analysis of the findings according to its requirements based on the definitions in the Stroke Rehab Definitions Framework.

The self-assessment surveys were analyzed in the spring of 2009.⁵ Self-assessment findings from a total of 57 stroke programs spanning acute care, inpatient and outpatient/ambulatory rehab and community-based rehab were reviewed. An analysis of the surveys highlighted the following key findings:

- Acute Care:
 - Of 14 programs, 5 acute care stroke programs met all 4 of the key criteria.
 - Almost all of the programs (93%) met the criterion to reassess stroke patients who are not initially eligible for inpatient rehab for their rehab needs.
 - Only half of the programs fully met the criterion to provide access to an interprofessional rehabilitation team with expertise in stroke care when the patient is rehab ready.
 - No programs provided all of the recommended core team members although all teams had nursing, physiotherapy, speech-language pathology and pharmacy and all but one program had access to a primary care physician, social work, occupational therapy and chaplaincy.
 - The availability of a physiatrist, rehab nurse and recreational therapists was not available in most programs.
- Inpatient High Tolerance Rehab:
 - Of 12 programs, only one program met all 9 key criteria.
 - Only half of the programs met the benchmark for a 2 day or less wait time for accessing inpatient rehabilitation following referral.
 - Most programs (83%) met the 24-48 hour benchmark to provide an early initial rehab assessment following admission.
 - Only 25% of the programs provided the recommended amount of therapy by occupational therapy, physiotherapy and speech-language pathology.
 - Although all programs provided the traditional rehab therapies, not all interprofessional teams included a rehab nurse, recreational therapist and physiatrist.
 - Most programs screened for the presence of cognitive deficits, falls, depression, behavioural issues and swallowing problems.
 - All programs provided information and education in the recommended areas (e.g. the nature of stroke, signs and symptoms, risk factors, resources and community support).
- Inpatient Low Tolerance Rehab:
 - Of 5 programs, no programs met all of the 9 key criteria.
 - 80% of the LTLD stroke rehab programs are provided on a stroke unit as recommended.

⁵ Analysis of the data was held up for the following reasons: (1) there were delays in receiving the data and; (2) the quality of the data from one of the stroke regional networks was questionable. As a result of these issues, the self-assessment findings were only analyzed relative to programs meeting the designated key criteria from the Stroke Rehab Definitions Framework.

- Approximately 60% of the programs provided the recommended amount of therapy; however, less than half of the programs initiated the first rehab assessment within 24-48 hours following admission.
 - The programs performed well with respect to meeting the criteria for the core team. That is, all programs provided a primary care physician, occupational therapy, pharmacy, geriatrician and psychiatry and most programs (80%) provided physiotherapy, speech-language pathology, social work and recreational therapy.
 - Only 1 program had access to a physiatrist.
 - All programs screened for cognitive deficits, falls, depression, behavioural issues and swallowing problems and all programs provided education and information in the recommended areas (e.g. the nature of stroke, signs and symptoms, risk factors, resources and community support).
- Outpatient/Ambulatory Rehab:
 - Of 13 programs offering an interprofessional stroke team approach and 10 programs providing outpatient single services, no programs met all key criteria.
 - In the 13 programs that provide an interprofessional team, only 4 programs provided most of the core team members recommended. Not all teams included a primary care physician or physiatrist, nurse, social worker, clinical dietician, pharmacist or recreational therapist.
 - Almost all interprofessional teams screen for cognitive deficits, falls, depression, behavioural issues and swallowing problems and all programs provided education and information in the recommended areas (e.g. the nature of stroke, signs and symptoms, risk factors, resources and community support).
 - There is a need to increase the use of a coordinated approach with formal team meetings and to accept referrals from long-term care.
 - No programs met the benchmark for the 5 day or less wait time for accessing outpatient/ambulatory rehabilitation following referral.
 - Community-Based Rehab:
 - Of 3 programs, one program, a community care access centre, met all 4 key criteria.
 - The other programs did not fully meet any of the key criteria.

In total, only 12% of the programs spanning acute care, inpatient and outpatient/ambulatory rehabilitation and community-based rehab met all of the key criteria for their sector. With the exception of LTLT rehab, most programs were unable to provide the recommended core team members. Most programs screened for cognitive deficits, falls, depression, behavioural issues and swallowing problems and provided education and information in the recommended areas (e.g. the nature of stroke, signs and symptoms, risk factors, resources and community support).

4.3 Spinal Cord Injury Rehab

The Spinal Cord Injury Rehab Definitions Framework was completed by the summer of 2008. A key differentiating feature of the Spinal Cord Injury Rehab Definitions Framework is its statement that a mixed rehab unit is not an appropriate setting for patients with spinal cord injury. The framework recommends that patients with a spinal cord injury require the expertise of rehab professionals in either a dedicated neuro rehab unit or a dedicated spinal cord injury unit. The framework provides differentiating criteria to distinguish which patients are appropriate for each of these settings.

Self-assessment surveys were disseminated in January 2009. A total of 17 surveys were received spanning acute care, inpatient, outpatient and community-based rehab programs. An analysis of the surveys highlighted the following key findings:

- Acute Care:
 - Only one of the three acute care units met all of the key criteria.

- All 3 acute care specialized neurological/neurosurgical units have dedicated core teams with expertise in spinal cord injury. Although these teams include the traditional rehab health providers (e.g. physician, nurse, physiotherapist, occupational therapist, speech-language pathologist, social work and pharmacist), there is a need for increased access to psychology across all programs. Increased access to peer support, respiratory therapy, nutrition and orthotist, chiropody and physiatry is needed in some programs as well.
- Education to patients/families is provided across all programs regarding changes in function and identification of rehab goals.
- Inpatient Rehab:
 - The one dedicated SCI rehab program participating in the survey met *all* criteria.
 - In the dedicated neuro rehab units, almost all of the recommended core team members are actively involved in assessment and treatment and participate in rounds regularly. Teams utilize a patient-centred, goal-oriented approach with established mechanisms of communication of goals and treatment plans with the patient/family; however, the intensity of treatment does not always meet the recommended level due to caseload demands.
 - There is a need for increased consultation between SCI rehab programs and neuro rehab programs for those SCI patients in neuro rehab who have complex needs and are awaiting admission to an SCI rehab program.
 - In LTLD rehab, there is a need for increased expertise in the treatment of neurological disorders and competence in skin, nutritional, bowel and bladder and seating management. There is also a need for increased access to specialized SCI services, pain services and SCI education.
- Outpatient/Ambulatory Rehab:
 - The dedicated SCI outpatient/ambulatory programs met all of the criteria
 - The dedicated interprofessional neuro teams have the required core team members and expertise in neurological disease; however, not all recommended consultative services are available (e.g. pharmacy, dietician, recreational therapy).
- Community-Based Rehab:
 - The 3 programs met the criteria for recommended core team members and services; however, specialization in spinal cord injury is lacking.

In total, of 17 programs surveyed, only 18% of the programs met all of the criteria in the SCI Rehab Definitions Framework and only 29% of the programs met all of the key criteria.

4.4 Oncology Rehab

The Oncology Rehab Definitions Framework was completed in the fall of 2008 and the self-assessment surveys were disseminated in March 2009. Self-assessment surveys were not distributed to acute care as there is no single oncology unit on which patients are seen; oncology patients are admitted to many different programs in acute care. In total, 21 surveys were received spanning inpatient and outpatient/ambulatory rehabilitation and community-based CCAC rehab programs. An analysis of the surveys highlighted the following key findings:

- Inpatient Rehab:
 - Neither of the two oncology rehab programs with a dedicated interprofessional oncology team met all of the criteria. However, one programs met all of the key criteria.
 - Of the six mixed rehab units that see oncology rehab patients, one program met all of the criteria and a third of the programs met all key criteria.
 - In general, the inpatient programs performed well with most programs meeting over 85% of all criteria.

- The inpatient rehab programs were generally able to provide the recommended core team members and the recommended amount of therapy. One program with a dedicated oncology rehab team, however, stated that it makes use of therapy assistants for more than the recommended amount of time.
- Areas for improvement include provision of recreational therapy, chaplaincy and wellness education. Some programs are unable to accommodate patients who need TPN, continuous infusion and/or oral chemotherapy.
- One program with a dedicated oncology rehab team does not accept patients who are undergoing chemotherapy treatment.
- Outpatient/Ambulatory Rehab
 - None of the dedicated or mixed population outpatient teams met all of the key criteria. Three of five single services met all of the key criteria.
 - The outpatient/ambulatory interprofessional rehab teams performed well with respect to the provision of the recommended services pertaining to the amount of therapy, access to a dedicated interprofessional team and the program's responsiveness to individual patient needs and goals. However, none of the teams met all of the key criteria.
 - Only half of the interprofessional teams included all of the recommended core team members and the required level of expertise in oncology diagnosis, prognosis, recovery and potential deficits.
 - Three of four team programs have a mechanism in place to support the re-entry of patients to be served.
 - No programs fully met the criterion regarding the participation of patient families in team meetings although families do provide input to individual team members.
- Community-Based Rehab
 - Two of three CCAC programs met all of the criteria and all of the key criteria; all programs met the criteria regarding the recommended team members, the services provided and the duration of involvement.
 - One program stated that although the CCAC service providers typically have the recommended skills and knowledge in oncology rehab, in the case of an urgent referral, a provider without the equivalent skill set may be sent in instead.

In total, of 21 programs surveyed, 29% of the programs met all of the criteria in the Oncology Rehab Definitions Framework and 38% of the programs met all of the key criteria.

4.5 ABI/Neuro Rehab

The ABI/Neuro Rehab Definitions Framework was completed in the winter of 2008. A key differentiating feature of the ABI/Neuro Rehab Definitions Framework is its statement that a mixed rehab unit is not an appropriate setting for all patients with an acquired brain injury. Specifically, those with moderate to severe cognitive/behavioural impairment should be referred to a unit with Dedicated Inpatient ABI Rehab beds. In addition, this framework includes criteria for a rehab service that is unique to brain injury (i.e., Transitional Behavioural Rehab in a Specialized Unit).

Self-assessment surveys were disseminated in the fall of 2008. A total of 22 surveys were received spanning acute care, inpatient, outpatient and community-based rehab programs. The process of conducting the self-assessments prompted the committee to make three adjustments to the Framework, requiring subsequent follow-up to ensure organizations met the additional/modified criteria.

An analysis of the surveys highlighted the following key findings:

- Acute Care:
 - Only one response was received from acute care.
 - That respondent met all criteria fully; however, the limited responses make it difficult to comment on system level performance.

- Inpatient Rehab:
 - Only 1 of the 3 programs offering ABI rehab on a dedicated inpatient rehab program met ALL of the key criteria.
 - 2 of the 3 dedicated ABI rehab programs reported having access to all core team members. For the organization that did not meet this criterion, neuropsychiatry and behavioural therapy were not part of the core team.
 - 100% of the dedicated ABI rehab programs reported having the recommended critical mass of beds and clustered the ABI beds geographically, facilitating the development and maintenance of expertise.
 - Only one of the dedicated rehab programs reported having a self-contained unit with appropriately secured access.
 - Intensity of treatment did not consistently meet the recommended level across all programs due to caseload demands.
 - Of the four programs offering ABI rehab in a mixed rehab unit, 50% have fully met the key criteria.
 - 100% of the programs reported have access to all core team members.
 - However, only 2 of the 4 reported having access to medical staff with expertise in ABI.
 - In LTLD ABI rehab, limited availability of medical staff with expertise in ABI is reported. The need to increase expertise in the management of severe ABI (i.e., with a Rancho Los Amigo score <4 or significant behavioural issues) and improve referral practices/consultation to link patients with specialized services and community support was also reported.
 - Although not identified as a key criterion there was consistent lack of access to psychology/psychiatry with neurological expertise across non-dedicated rehab programs.

- Outpatient/Ambulatory Rehab:
 - 8 responses were received for outpatient/ambulatory rehab (mixed, dedicated, and single service).
 - The outpatient rehab teams performed well with respect to the core team members required. One program reported having access to a physician but not to a physiatrist.
 - A coordinated team approach is consistently being used with regular team meetings for the 6 Dedicated and Mixed Outpatient ABI Teams.
 - Increased availability of 'within and between service case management or equivalent is needed to facilitate access to services through the continuum of care.
 - Although not identified as a key criterion, wait times for outpatient rehab are frequently exceeding the recommended guidelines of access within 5 business days.

- Community-Based Rehab:
 - Both CCAC's responding met the criteria for recommended core team and coordinate activity through regular team conferences
 - Only 1 of the 2 CCAC's reported having consistent access to health professionals with expertise in ABI/Neuro.
 - Vocational rehab and anger management was not consistently available.

4.6 Cardiac Rehab

The Cardiac Rehab Definitions Framework was completed in summer of 2008. The development of a Definitions Framework for cardiac rehab was different for a number of reasons. First, there is an abundance of evidence in cardiac rehabilitation which shows its effectiveness. Through the process of developing this evidence, core components of rehabilitation programs have already been established and

in many cases formalized. In spite of this evidence, cardiac rehabilitation programs are sparse; have not had funding renewed to them; and continue to be underutilized. Given this context it was agreed that the Rehabilitation Definitions Framework will be applied to cardiac rehabilitation with a view to utilizing the resulting document to refresh the dialogue on the importance of cardiac rehabilitation at both the level of the system and the level of the patient.

This work was supported by the Cardiac Care Network and the Cardiac Rehab Network of Ontario both through reliance on work they had undertaken in developing standards of care for cardiac rehab and through their direct involvement in the committee's deliberations.

The majority of the Framework was completed in early 2009 but a decision was made to defer finalizing the Framework and conducting the self assessment surveys until after the release of the third edition of the Canadian Guidelines for Cardiac Rehabilitation and Cardiovascular Disease Prevention. This provided the opportunity to ensure the definitions were as complete and up to date as possible. The Framework has now been modified to reflect the most recent Canadian Guidelines and the self-assessment surveys are in the process of being completed. We anticipate having the survey results in the spring. Once the results are received the Committee will reconvene to review the analysis, establish key criteria, and determine opportunities for next steps.

4.7 Amputee Rehab

The Amputee Rehab Definitions committee was formed in February 2009. The framework was completed in June 2009. Two key differentiating features of the Amputee Rehab Definitions Framework were: (1) a recommendation that inpatient dedicated rehab programs have dialysis services on site; and (2) a recommendation that an amputee rehab program be considered as an integrated system of care that includes inpatient care, outpatient care and an ADP Clinic. The task group recognized that a full program may not be housed within one facility, but recommended that such partnerships would need to be formed to ensure efficient patient flow and communication across teams.

Self assessment surveys were disseminated in July 2009. Seventeen self assessment surveys were received from acute care, inpatient rehab, outpatient rehab and community rehab programs. An analysis of the surveys highlighted the following key findings:

- Acute Care:
 - None of the 3 programs met all of the key criteria.
 - Although all 3 programs had 80-100% of the recommended core team members, all 3 were also missing 50-60% of the consultative team. There is a need for increased access to a physiatrist, psychologist, neuropsychologist, trained peer visitor and prosthetist.
 - None of the programs provided the recommended pre-operative activities.

- Inpatient Rehab:
 - *Dedicated Amputee Rehab Team on a Mixed Rehab Unit*
 - None of the 3 programs met all the key criteria (note that 1 survey was incomplete and could not be fully analyzed).
 - Although all programs were able to provide the recommended intensity and frequency of therapy, none were able to meet all of the criteria for specialization (i.e. critical mass, geographical clustering, ADP clinic number).
 - One of the programs was not able to offer a dedicated team within the mixed unit.

 - *Dedicated Amputee Rehab Unit*
 - For the purpose of analysis, the key criterion related to availability of on-site dialysis was excluded. As such, one program of the two met all of the key criteria for a dedicated amputee rehab program.
 - Both programs offered the recommended intensity and frequency of therapy and nearly all of the recommended interprofessional team members.
 - Areas of improvement include consistently incorporating sexuality and end of life decision making as part of the key activities.

Low Tolerance Long Duration (LTLTD) Rehab

- The sole program which responded to this survey did not meet all of the key criteria.
- Although this program was able to provide all of the recommended core team members, a dedicated team was not available for the majority (80% or more) of the time.
- Areas of improvement include matching the recommended intensity and frequency of therapy recommended, geographically clustering beds and consistently incorporating more of the recommended key activities.

▪ Outpatient/Ambulatory Rehab:

- Of the 5 programs which responded to this survey, none met all of the key criteria.
- Most programs offered the recommended core team members and had an ADP clinic number and rehab assessor.
- Only one program was able to meet the recommendation for access to outpatient rehab within 1 week of discharge from inpatient rehab/acute care.

▪ Community-Based Rehab:

- Of the 3 programs which responded to this survey, one met all of the key criteria. Note that one survey was incomplete and could not be fully analyzed.
- Most of the programs reported that the community based rehab providers have contact with the amputee rehab team and that services are in place until identified goals have been met or are otherwise addressed.
- One program identified that although it met most of the criteria, it does not consider itself an amputee rehab program due to low volumes.

In total, of the 17 programs surveyed, none of the programs met all of the criteria in the Amputee Rehab Definitions Framework and only 13% of the programs met all of the key criteria.

4.8 Pulmonary Rehab

The Pulmonary Rehab Definitions committee was formed in February 2009. The framework was completed in August 2009. A differentiating feature of the Pulmonary Rehab Definitions Framework is a statement that a mixed rehab unit is not an appropriate setting for patients requiring pulmonary rehab. This framework specifies that either patients should receive services from a dedicated pulmonary rehab team on a mixed rehab unit, or that patients should receive services from a dedicated pulmonary rehab unit. The task group also made specific recommendations regarding the competencies expected and the intensity and frequency of therapy recommended for best practice in pulmonary rehab.

Self assessment surveys were disseminated in August 2009 across the Greater Toronto Area. Twenty self assessment surveys were received from inpatient rehab, outpatient rehab and community rehab programs. An analysis of the surveys highlighted the following key findings (note that not all surveys were fully complete):

▪ Inpatient Rehab:

Dedicated Pulmonary Rehab Team on a Mixed Rehab Unit

- 1 out of the 4 programs met all of the key criteria
- 3 out of the 4 programs provided the intensity, frequency and duration of rehab that were recommended
- 3 of the programs did not meet the dedicated space and/or volume recommendations.

Dedicated Pulmonary Rehab Unit

- The sole program which provided this level of rehab met all of the key criteria

Low Tolerance Long Duration (LTLTD) Rehab

- 1 of the 2 programs met all of the key criteria
- All programs were able to provide the level of specialization that was recommended.
- 1 program did not provide the intensity and frequency of rehab recommended or provide the level of staffing needed to support the recommended amount of therapy.
- 1 program did not provide all components of self management that were recommended

- Outpatient/Ambulatory Rehab:

- *Outpatient Mixed Rehab*

- 1 program filled out this survey and did not meet all of the key criteria.
- This program was not able to provide the recommended core and consultative team members
- Some components of the recommended key activities and assessments were not provided.

- *Outpatient Dedicated Rehab*

- 9 programs filled out this survey, of which 7 were sufficiently completed to analyze the key criteria. Of the 7 surveys which could be analyzed, 3 of them met all of the key criteria.
- 3 programs were not able to provide the frequency of supervised exercise sessions and/or the total number of supervised exercise sessions.
- 3 programs were not able to provide consultation services by a social worker and a Respiriologist.

- Community-Based Rehab:

- Of the 3 programs which responded to this survey, none could be fully analyzed.
- All of the programs provided rehab based on the client's needs and goals
- 2 of the programs provided the services that were recommended for community pulmonary rehab

In total, of the 20 survey responses, 33% met all of the criteria in the Pulmonary Rehab Definitions Framework (excluding those which were incomplete) and 40% of the programs (excluding those which could not have the key criteria analyzed) met all of the key criteria.

4.9 Burn Rehab

The Burn Rehab Definitions committee was formed in February 2009. Unlike its predecessors, the small size of the burn rehab community and the interconnectedness of the provincial Burn Centres with the outlying community partners across the province necessitated a provincial committee. In addition, this is the first committee that has incorporated paediatrics into the framework. This was done because of the interconnected nature of the paediatric and adult burn rehab systems in Ontario. The committee meetings have been conducted using videoconferencing technology to bring provincial partners together.

The Burn Rehab Definitions Framework was completed in February, 2010. This framework outlines specific competencies and timelines for burn rehab. In acute and inpatient rehab, for example, the task group recommended that no more than 24 hours occur between therapy sessions. The task group also recommended that access to outpatient rehab occur within 72 hours of referral from for burns to critical areas (defined as: face, hands, feet, genitalia, perineum or major joints) and within 7 days for all other burns.

Self assessment surveys were distributed to 33 rehab programs serving the burn population across the province in March, 2010. A final meeting is planned for end of April/early May to review the results of the analysis and discuss next steps.

4.10 MSK/Trauma Rehab

The MSK Rehab Definitions Framework was initiated in May, 2009 and is the last of the frameworks to be completed. The MSK committee has determined that more than one framework is required to fully capture the complexities of this population. The committee completed work on the Total Joint Replacement Rehab Definitions Framework as well as the Hip Fracture Rehab Definitions Framework in March, 2010.

A key differentiating feature of the Total Joint Replacement Rehab Definitions Framework is the recommendation that the majority of typical patients with primary, elective total hip or knee replacements, should not go to inpatient rehab. Rather, the task group has recommended that these patients receive their post-acute rehab through outpatient or community services, given evidence that similar outcomes can be achieved. The framework also outlines circumstances where patients may require inpatient rehab.

Conversely, a key differentiating feature of the Hip Fracture Rehab Definitions Framework is the recommendation that all patients be considered for inpatient (high tolerance, short duration) rehab for their post-acute care, unless they are safe for discharge home. The task group outlined several Guiding Principles for hip fracture rehab, including: patients from all types of pre-morbid living situations should be considered equally with regard to decision making for inpatient rehab admission and that all patients with mild to moderate cognitive impairment should be considered equally with those who are cognitively intact with regard to decision making for inpatient rehab admission.

In addition, for both sub-population groups, the task group recommended that rehab should occur either on a dedicated MSK/Ortho unit/program, or that a dedicated MSK/Ortho rehab team provide rehab on a mixed population (general rehab) unit.

Self assessment surveys were disseminated in March with a final meeting planned for late April/early May to review the results of the analysis.

5.0 Key Messages

5.1 *Challenges in developing the definition frameworks*

A common challenge experienced by each of the rehab definition task groups involved reconciling the tension between what *ought* to be provided in rehab (i.e. recommending a “gold standard” of practice) and what *can* be provided within current funding restraints. Task group members often struggled with setting high standards for rehabilitation knowing that in reality, some of the definitions would not be met by most or all programs. For example, task group members often found it initially difficult to support the inclusion of “gold standard” practices when they were acutely aware that there was a lack of resources to provide the recommended staffing complement or to accommodate a special need (e.g. TPN or dialysis).

Task group members also struggled with recommendations that at times ran counter to the very real demands placed on organizations to meet the needs of patients within their catchment areas. As an example, the inability to adhere to the recommendations for having the required critical mass of patients for a particular rehab population (e.g. stroke) to develop and maintain the recommended level of expertise might mean that a rehab unit in an acute care community hospital would decide to no longer provide stroke rehab to patients on its mixed unit, even though it would be closer to home for patients within their catchment area.

Nevertheless, despite these challenges, task group members accepted that it was important to set high standards towards which organizations could strive rather than develop definitions that reflected the status quo in rehab programming, where there are known gaps in the type and amount of services provided.

5.2 *What can we do better?*

The discussions throughout the development of the various rehab definition frameworks have led to a better understanding of current rehab services and areas for improvement. The initiative has highlighted that although rehab programs are organized around various rehab population groups (e.g. stroke, burns, spinal cord injury), the rehab needs of patients are often not ‘organized’ in the same way. For example, a patient with spinal cord injury might also have a brain injury. A patient who has suffered a stroke might also be a frail senior and present with a number of other needs.

In a similar vein, rehab programs do not always provide the flexibility that is needed to accommodate patients who, in addition to their rehab needs, may also require other medical treatments at the same time. For example, a rehab patient may require dialysis at the same time as she/he is participating in an inpatient rehab program.

The discussions that occurred among task group members as the rehab definition frameworks were developed have highlighted the following issues:

1. There are significant gaps in the system's ability to address the needs of rehab patients with multiple diagnoses and/or special needs. Specifically,
 - Structured mechanisms are required to support cross-program consultation regarding the treatment of patients with multiple diagnoses.
 - The top special care needs of patients referred to inpatient rehab and CCC whose referrals are denied by all organizations are: skin condition; equipment needs and IV (High Tolerance Long Duration rehab); IV, skin condition and oxygen (Low Tolerance Long Duration rehab); and behavioural issues, enteral feeds, oxygen, equipment needs and skin condition (CCC).⁶ While each of these special care needs can be accommodated by most organizations, it is the combination of special care needs and comorbid conditions that tends to delay or prevent access to rehab and CCC.
 - The two top reasons for denial of referrals to inpatient rehab and CCC by all programs are that the patient is "not rehab ready" and "medical needs cannot be accommodated."⁷ On-site access to diagnostic services and other resources are needed to address the medical complexity of patients referred and their special needs/comorbid conditions (e.g. dialysis)⁸ to support the delivery of rehab that is responsive to patient needs and maximizes access to and the efficient use of rehab services.

2. There is a need to re-examine the philosophy of care by which rehab is provided to build in program flexibility to meet patient need. Considerations in this regard include the following.
 - There is a need for increased competencies in the areas of impaired cognition and senior-focused principles of care across all rehab programs⁹ to better meet the needs of rehab patients, almost half of whom are over 74 years of age¹⁰. Enhanced expertise would increase access to timely and quality rehab care.
 - The complexity of rehab patients today due to the presence of comorbidities and chronic disease calls for the re-examination of how rehab programs are delivered and/or measured. For example,
 - ▶ Lower length of stay benchmarks tend to serve as a disincentive to admit more complex patients who could benefit from a rehab program but who would likely to exceed the average length of stay target for the program. Monitoring of length of stay alone in absence of understanding patient complexity and number of patients seen can drive performance in a direction that is not consistent with system goals of patient flow and reduction of ALC.
 - ▶ The evidence outlined in the rehabilitation frameworks could be used as a basis to inform a more appropriate combination of indicators for performance measurement to support better flow and quality of care.
 - ▶ A review of organizational processes involved in the scheduling of treatment sessions, which is typically based on a regular 9:00 to 5:00 business day schedule, is warranted to determine if these processes adversely affect clinical outcomes and length of stay

3. The amount of therapy that is recommended for high tolerance rehab in the rehab definition frameworks calls for a staffing ratio of *1 rehab therapist for every 6 rehab beds*. A recent polling by the Network of

⁶ These special needs are based on data from the TC LHIN's Resource Matching and Referral monthly reports from August 2009 to February 28, 2010.

⁷ Top reasons for denial are based on data from the TC LHIN's Resource Matching and Referral monthly reports from August 2009 to January 31, 2010.

⁸ The average number of comorbid conditions among inpatient rehab patients at admission increases with average client age. Hypertension and Type I or Type II Diabetes Mellitus (often associated with chronic renal failure) were among the top three co-morbid conditions among older rehab patients. Canadian Institute for Health Information. Inpatient Rehabilitation in Canada, 2003-2004. Special Topic: A Look at the Older Population. (2005)

⁹ Integrating senior-focused principles of care across *all* sectors of the care continuum is recommended to reduce the risk of adverse events, maximize health outcomes, independence and overall well-being.

¹⁰ Canadian Institute for Health Information. Inpatient Rehabilitation in Canada, 2003-2004. Special Topic: A Look at the Older Population. (2005). In addition, findings from the TC LHIN Resource Matching and Referral System (RM&R) monthly reports indicates that on average, 62% of patients referred through the electronic RM&R system are 70 years of age or older (YTD figures, April 2009 – February 2010).

the staffing ratios across programs indicates that this “gold standard” for the delivery of rehab services is rarely met.

- In dedicated rehab programs (i.e. dedicated to specific rehab population) on average, 1 physiotherapist is available for every 8 beds; 1 occupational therapist is available for every 10 beds and 1 speech-language pathologist is available for every 23 beds or on consult basis only.
- In mixed rehab programs, on average, 1 physiotherapist is available for every 9 beds; 1 occupational therapist is available for every 10 beds and 1 speech-language pathologist is available for every 40 beds.

6.0 Next Steps

- i) The Network will meet with the Rehab Definitions Advisory Committee to discuss the following proposed plan for reviewing and updating each of the rehab frameworks to ensure they are consistent with emerging evidence and current models of practice. The review will be conducted in a 2-staged process over this year to first address the frameworks completed in the earlier phase of the initiative. The frameworks that were completed earlier this year will be reviewed in the second stage of this process.
- ii) The Network will explore the requirements (technical and cost-related) for modifying Rehab Finder to enable the inclusion of self-assessment findings as a basis for streamlining and organizing its listing of rehab programs.
- iii) In June, 2009, the Network held a strategic planning session with its members in which the Network received clear endorsement to focus on the development of performance indicators for rehabilitation. In response to this feedback, the Network will examine how the Rehab Definitions initiative and its findings can inform the identification of health system performance indicators for rehabilitation. The identification of performance indicators and benchmarks will be based on (1) their relevance to rehabilitation, clinical outcomes and administrative processes (e.g. wait times); and (2) their alignment with the rehab definition frameworks across rehabilitation sectors (e.g. inpatient rehab, outpatient rehabilitation). This work may also include the identification of indicators specific to the measurement of structured mechanisms that facilitate cross-program consultation. The Network has submitted preliminary considerations for the development of such indicators and benchmarks to the TC LHIN in its December 2009 report, System Performance Indicators for Rehabilitation/CCC.
- iv) The Network will communicate a summary of the findings from the self-assessment surveys to senior administration at each member organization and information about the key learnings from the initiative, including aggregate findings from the self-assessment surveys.
- v) The GTA Rehab Network will be working to use the results from the self-assessment surveys along with information from other data sources (e.g. NRS, TC LHIN RM&R system) to further investigate current rehab capacity, demand and gaps in services across the freestanding rehab/CCC hospitals as the Network moves forward to support system improvement and planning.

APPENDIX A: REHAB DEFINITIONS ADVISORY COMMITTEE & TASK GROUP MEMBERSHIP

Rehab Definitions Advisory Committee	
GTA Rehab Network Staff Support: Charissa Levy, Executive Director; Sue Balogh, Project Planner/Coordinator	
<p>Dr. Mark Bayley, Medical Director, Neurorehab Program, Toronto Rehab (Chair) Donna Barker, University of Toronto Angela Chan, Baycrest James Fox, Providence Healthcare Kim Grootveld, St. Michael's Hospital Lynn Guerriero/Sandy Cox, Bloorview Kids' Rehab</p>	<p>Mary Ann Neary, University Health Network Linda Marabini, Castletown-Wychwood Towers Heather Brien/ Sharon McCarthy, TC CCAC Cathy Pierce, Markham Stouffville Hospital Heather Reid, Rouge Valley Health System Karyn Lumsden, Credit Valley Hospital</p>
ABI/Neuro Rehab Definitions Task Group	
GTA Rehab Network Staff Support: Charissa Levy, Executive Director; Judy Moir, Project Planner/Coordinator	
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Amputee Rehab Definitions Task Group	
GTA Rehab Network Staff Support: Charissa Levy, Executive Director; Sarah Dimmock, Project Planner/Coordinator; Hannah Seo, Project Planner/Coordinator	
<p>Dr. Michael Devlin, Physiatrist, West Park Healthcare Centre (Chair) Sandy Beckett, Credit Valley Hospital Janet Body, West Park Healthcare Centre Shirlene Campbell, St. John's Rehab Hospital Karen Fairley, SCIL – Sunnybrook Health Sciences Centre</p>	<p>Stefania Lehkyj, West Park Healthcare Centre Jane Turner, West Park Healthcare Centre Brad VanLenthe, Bloorview/Private Practice Julia Filinski, Providence Health Judy Langford, Calmar Orthopaedics</p>
Burns Rehab Definitions Task Group	
GTA Rehab Network Staff Support: Charissa Levy, Executive Director; Sarah Dimmock, Project Planner/Coordinator; Hannah Seo, Project Planner/Coordinator	
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Cardiac Rehab Definitions Task Group

GTA Rehab Network Staff Support: Judy Moir, Project Planner/Coordinator; Tina Saryeddine, Project Planner/Coordinator

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 Carol Ois/Collene Traille-Brown, William Osler Health Centre
 Heather Haines, Credit Valley Hospital
 Janet Domingues, Southlake Regional Health Centre
 Jim Pagiamtzis, Cardiac Care Network of Ontario
 Linda Nasturzio, St. John's Rehab
 Margaret Williams, St. Joseph's Health Centre

Martha Strong, Toronto Rehab
 Nicole Smith, St. Joseph's Health Centre
 Paul Sawyer, Lakeridge Health
 Terry Fair, Trillium Health Centre
 Marc Davies, William Osler Health Centre
 Monica Panetta, Credit Valley Hospital
 Pat Scholey, Cardiac Care Network

Pulmonary Rehab Definitions Task Group

GTA Rehab Network Staff Support: Charissa Levy, Executive Director, Sarah Dimmock, Project Coordinator/Planner; Hannah Seo, Project Coordinator/Planner

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 Debbie Coutts, Credit Valley Hospital
 Kristine Weinacht, Toronto East General Hospital

Raj Kohli, West Park Health Care Centre
 Maria Lahey, Trillium Health Centre
 Carole Madeley, The Lung Association
 Shirley Price, West Park Health Care Centre

Geriatric Rehab Task Group

GTA Rehab Network Staff Support: Charissa Levy, Executive Director; Sue Balogh, Project Planner/Coordinator; Kathy Wheeler, Consultant

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 Judy Bonham, Bridgepoint Health
 Tanya Diamond, York Central Hospital
 Alexis Dishaw, Toronto Grace Health Centre
 Dr. John Flannery, Toronto Rehab
 James Fox/ Carol Jarman, Providence Healthcare
 Linda Jackson, Baycrest
 Dr. Barbara Liu, Regional Geriatric Program of Toronto

Mary Lynne MacMaster/ Sandra Dickau, St. Joseph's Health Centre
 Paul Man-Son-Hing, Toronto East General Hospital
 Kim Kohlberger, Halton Healthcare Services
 Donna Renzetti, West Park Healthcare Centre
 Sandra Tully, UHN – Toronto Western Hospital
 Laurence Wolfson, William Osler Health Centre
 Charlie Yang, St. Michael's Hospital
 Dr. Shelly Veinish/ Angela Chan, Baycrest
 Anne Stephens, St. Michael's Hospital

Oncology Rehab Definitions Task Group

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Gerry Beaudoin, Sunnybrook Health Sciences Centre
 Susan Blacker, St. Michael's Hospital
 Robin Forbes, Princess Margaret Hospital/University Health Network
 Barbara Jackson, Sunnybrook Health Sciences Centre
 Gina Lam, St. John's Rehab Hospital
 Amber Oke, Mt. Sinai Hospital

Lisa Rezler, Toronto CCAC
 James Fox, Providence Healthcare
 Cathy Lacombe, Providence Healthcare
 Linda Nasturzio, St. John's Rehab Hospital
 Heather Flett, Lyndhurst Centre/Toronto Rehab
 Barb Hooper, St. Michael's Hospital
 Renay Benlolo, Hillcrest Centre/Toronto Rehab
 Mandy McGlynn, Hillcrest Centre/Toronto Rehab

MSK/Trauma Rehab Definitions Task Group

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Angela Chan, Baycrest Hospital
 Sang Choi, Credit Valley Hospital
 Dr. Aileen Davis, University Health Network
 Joan DeBruyn, Trillium Health
 Lori Edwards / Derek Glazier, Toronto East General Hospital
 Dr. John Flannery, Toronto Rehabilitation Institute
 Maureen Hunt, Rouge Valley Health System
 Gerry Hubble, Sunnybrook Health Sciences Centre
 Debbie Kennedy, Sunnybrook Health Sciences Centre
 Crystal MacKay, ACREU

Dr. Kathy McGilton, Toronto Rehabilitation Institute
 Mandy McGlynn, Toronto Rehabilitation Institute
 Janet Mulgrave, West Park Healthcare Centre
 Leeanne Smith / Julie Langton, Lakeridge Health
 Leslie Soever, Mt. Sinai Hospital
 Ruth Ann Sullivan, Providence Health
 Dr. Sharon Switzer-McIntyre, University of Toronto
 Dr. Fiona Webster, Sunnybrook Health Sciences Centre
 Riki Yamada, Southlake Regional Health Centre
 Bayla Zahler, Bridgepoint Health

Spinal Cord Injury Rehab Definitions Task Group

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 Peter Athanasopoulos, Canadian Paraplegic Association Ontario
 Dr. Anthony Burns, Toronto Rehab
 Karen Davies, Toronto CCAC
 Andrea Dyrkacz, University Health Network
 Heather Flett/Kristina Guy, Toronto Rehab
 Dr. Chantal Graveline, Toronto Rehab
 Jacqueline Houston, St. Michael's Hospital

Nick Ioannidis/Bonnie Smith, Toronto Rehab
 Chantal Letang, Sunnybrook Health Sciences Centre
 Janet Mulgrave, West Park Healthcare Centre
 Linda Nasturzio, St. John's Rehab Hospital
 Tracy Paulenko, Toronto Rehab
 Nijole Simonavicius, Trillium Health Centre
 Kevin White, University Health Network
 Meredith Burley, Canadian Paraplegic Association Ontario

Stroke Rehab Definitions Task Group

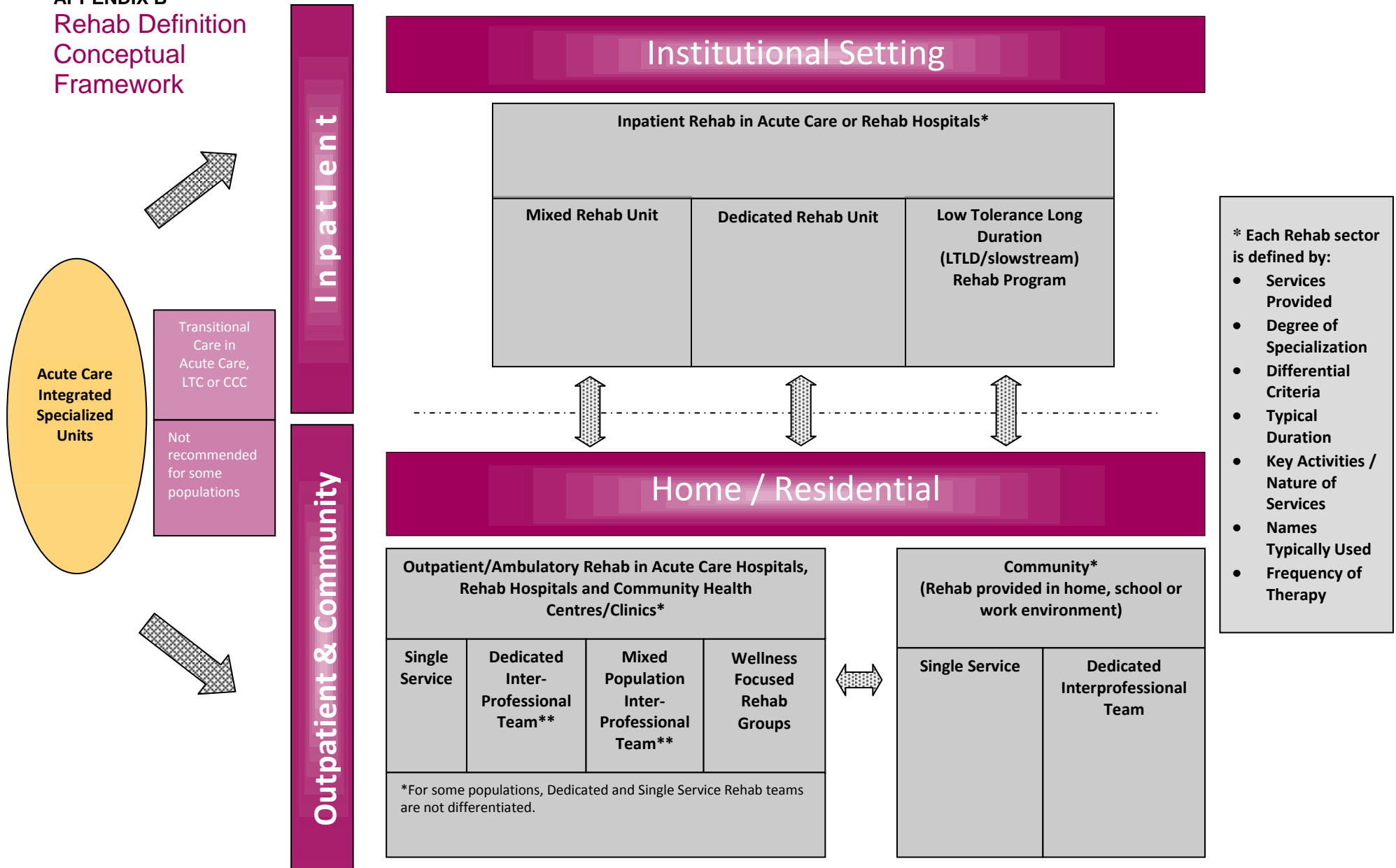
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 Catherine Chuang, St. John's Rehab Hospital
 Jackie Eli, Program Bridgepoint Health
 Anne McEwen, St. John's Rehab Hospital

Caroline Gangji, Heart and Stroke Foundation of Ontario
 Joanna Schechter, Baycrest
 Maria Huijbregts, Baycrest
 Anita Jacobson, Scarborough CCAC
 Carol Jarman, Providence Healthcare
 Dr. Dmytro Rewilak, Psychiatry Program and Stroke Clinic, Baycrest
 Shelley Santerre, Lakeridge Health
 Dr. Jon Ween, Stroke Clinic, Brain Health Clinic, Baycrest
 Carmel Forrestal, West GTA Stroke Network

APPENDIX B
Rehab Definition
Conceptual
Framework



GUIDING PRINCIPLES

OBJECTIVES:

I. Increase clarity and consistency in the forms of cognitive and physical rehab across the continuum by:

1. Clarifying the distinctions between and across institutional and community-based rehab programs.
2. Classifying programs with consistent terminology.
3. Describing the key features of institutional and community-based rehabilitation programs based on the services provided, the degree of specialization, differential/critical criteria, duration, and the primary focus of the rehab program/service.

II. Inform planning and performance measurement through the development of standards for rehab program components against which rehab programs can be benchmarked.

GUIDING PRINCIPLES:

1. The Rehab Definitions Conceptual Framework presupposes the World Health Organization's definition of "rehabilitation" as "*a progressive, dynamic, goal-oriented and often time-limited process, which enables an individual with an impairment to identify and reach his/her optimal mental, physical, cognitive and/or social functional level. Rehabilitation provides opportunities for the individual, the family and the community to accommodate a limitation or loss of function and aims to facilitate social integration and independence.*"
2. The Rehab Definitions Conceptual Framework refers to cognitive and physical forms of rehabilitation across the continuum. The rehab conceptual diagram refers to acute care, inpatient rehab programs within institutional settings and outpatient and community-based rehab for clients residing at home or in a residential setting. The use of bi-directional arrows in the schematic reflects the flow of patients and continuity of care across these settings.
3. The framework identifies key features of rehab programs based on evidence-based practices where available to define the "gold standard" of rehab care (e.g. rehab beds are clustered together). In most instances these key features reflect current practices; however, some organizations may be required to implement changes within their organizations to achieve consistency with the criteria set out in the framework.
4. The term "patient" is used for individuals receiving rehabilitation in a hospital setting. The term "client" is used to refer to individuals receiving community rehab services.
5. The Rehab Definitions Conceptual Framework uses categories that have been defined based on the rehab needs of the patient and the typical services provided. Length of stay or the type of facility in which the rehab is provided is not considered essential to defining rehab sectors.
6. The Rehab Definitions Conceptual Framework is based on the assumption that clients participating in the programs described have rehab potential and rehab goals. For criteria regarding rehab potential, medical stability and rehab readiness for inpatient rehab, refer to the GTA Rehab Network's Inpatient Rehab Referral Guidelines (www.gtarehabnetwork.ca).
7. The framework uses terminology that is consistent with the MOHTLC guidelines for inpatient rehabilitation beds and can be applied to community and ambulatory service delivery.
8. While it is appreciated that much of rehabilitation occurs in third-party payer assessment centres or private clinics, the framework refers to publicly-funded rehabilitation. However, it is hoped that the framework will promote consistency in standards of care and equitable access across all rehab programs.
9. Input from healthcare providers representing acute care, regional rehab centres and community-based organizations that provide adult (including geriatric) and paediatric rehab has been obtained to validate the Rehab Definitions Conceptual Framework.

GLOSSARY OF REHAB COMPONENT TERMS

Core Team: Core team refers to the team members who are essential, actively involved in the assessment and treatment (if required) of rehab patients on the unit and who participate regularly in team rounds.

Dedicated Interprofessional Team (Community): Rehab provided in the home, school or work environment by an interprofessional team using a coordinated, integrated approach for specific rehab populations or to reduce the impact of a particular disability.

Dedicated Interprofessional Team (Outpatient/Ambulatory Rehab): Outpatient rehab provided by an interprofessional team with expertise in the treatment and assessment of a particular patient population. Outpatient/Ambulatory dedicated interprofessional teams are located in acute care hospitals, rehab hospitals and community health centres/clinics. They provide rehab to patients who require more than one rehab service and a coordinated rehab approach.

Dedicated Rehab Unit: An inpatient rehab unit located in acute care and rehab hospitals that serves a single patient population group and provides intensive rehabilitation. Some units may specialize in more than one diagnosis in related populations (e.g. Cardio/Respiratory, Orthopaedic/Amputation, etc.). A dedicated rehab unit is suitable for individuals who require 24-hour hospital care and who are in need of an interprofessional rehab program using a coordinated rehab approach.

Low Tolerance Long Duration (LTLD/slowstream) Rehab Program: Suitable for individuals in need of an interprofessional rehab approach to address specific rehab goals who also have chronic/complex conditions requiring 24-hour hospital care and who are expected to benefit from a slower-paced rehab program for a longer duration than is offered in dedicated or mixed rehab programs. LTLD rehab is most commonly delivered in a complex continuing care bed but may also be provided in a designated rehab bed. LTLD rehab programs may be located in acute care, rehab or complex continuing care hospitals.

Mixed Population Interprofessional Team (Outpatient/Ambulatory Rehab): Outpatient rehab that is provided by an interprofessional team, which typically assesses and treats patients from a variety of patient population groups. Outpatient/Ambulatory mixed population interprofessional teams are located in acute care hospitals, rehab hospitals and community health centres/clinics. They provide rehab to patients who require more than one rehab service and a coordinated rehab approach.

Mixed Rehab Unit: Formerly referred to as a General inpatient rehab unit, this type of unit is located in acute care and rehab hospitals, provides intensive rehabilitation and serves a variety of patient population groups. The mixed rehab unit is suitable for individuals who require 24-hour hospital care and are in need of an interprofessional rehab program using a coordinated approach.

Single Service (Community): Individual rehab services that are usually provided through Community Care Access Centres. Single rehab services are suitable for individuals who are in need of one or more rehabilitation services in single specialty area(s)/profession(s) provided in the home, school or work environment. Although clients may receive more than one service, a coordinated approach is not used as rehab providers typically work as individual providers. However, some communication with other health providers may occur on an as-needed basis.

Single Service (Outpatient/Ambulatory Rehab): An outpatient rehab service located in acute care hospitals, rehab hospitals and community health centres/clinics that is suitable for individuals who are in need of an outpatient rehabilitation service in a single specialty area/profession. Clients may receive more than one rehab service; however, the services are not provided by way of a coordinated rehab approach. Services may include assessment only or assessment and treatment. Services may be provided during a one-time visit or multiple visits.

Wellness Focused Rehab Groups: These groups are provided in an outpatient/ambulatory setting and led by an individual rehab provider or team or rehab specialists to enhance an individual's ability to cope with a particular disability or impairment. These time-limited groups are publicly-funded although a small fee may be charged for materials.



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