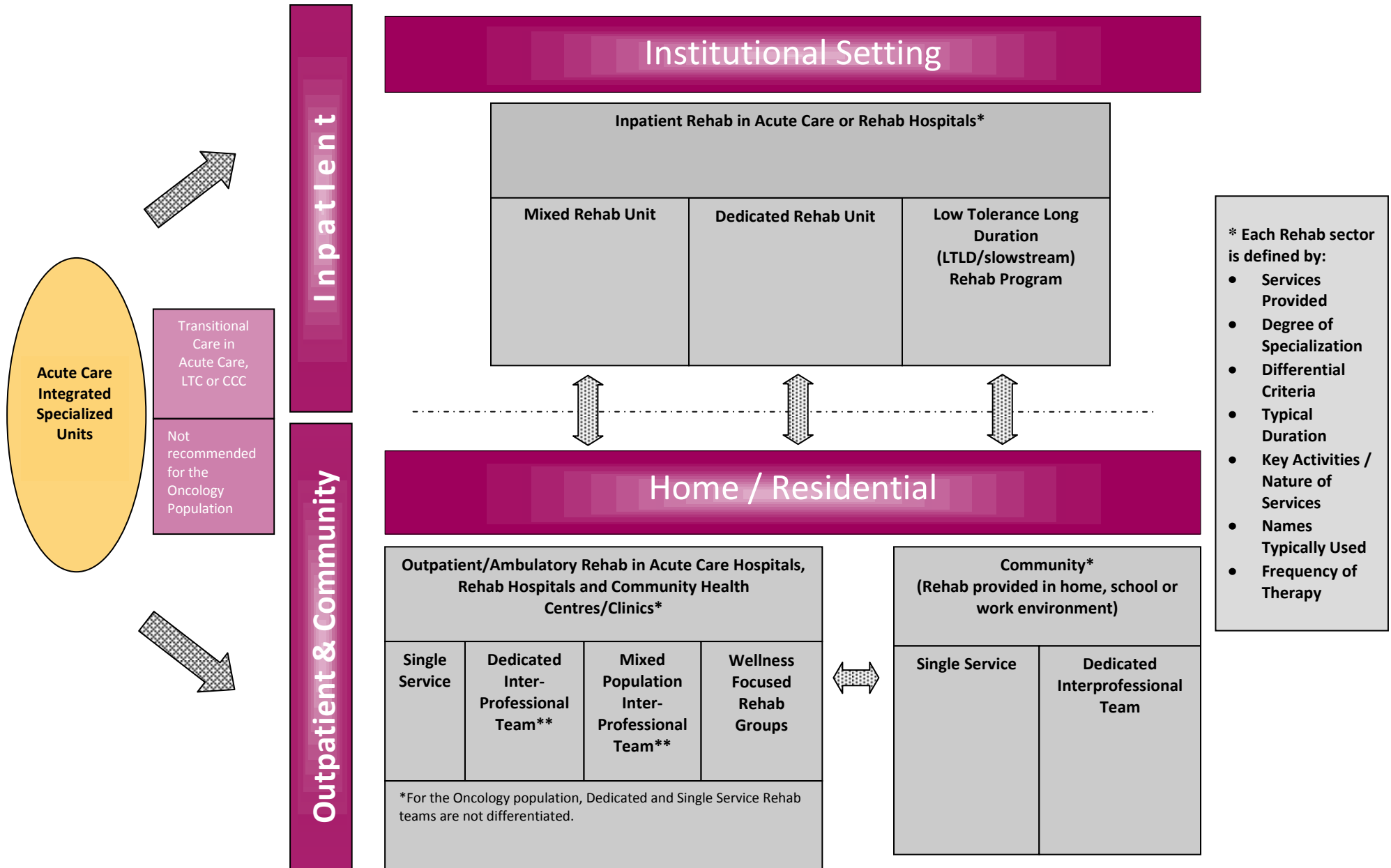


Oncology Rehab Definition Framework

This framework applies to individuals who have rehab potential and identified rehab goals



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.

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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

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: Located in acute care and rehab hospitals, LTLD rehab is suitable for individuals in need of an interprofessional rehab program who may also have a chronic/complex condition requiring 24-hour hospital care over an extended period of time and who are expected to benefit from a slower-paced rehab program for a longer duration than is offered in dedicated or mixed rehab units.

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.

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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.

ACUTE CARE	
Acute Care Medical/Surgical Units	
The rehabilitation needs of all patients should be assessed throughout the cancer pathway and particularly at times that present patients and caregivers with increased challenges.¹	
Names Typically Used	<ul style="list-style-type: none"> • Patients may be located on the following units: Surgical Oncology; Medical Oncology; Radiation Oncology; Solid Tumour and Haematology; or other specialized acute care units: e.g. Ortho, Neurosurgery, General Medicine, Thoracic
Services Provided	<ul style="list-style-type: none"> • Physician services (e.g. Oncologist, Radiologist, Surgeon); Nursing (RN); Physiotherapy (PT); Occupational Therapy (OT); Speech Language Pathology (SLP); Nutrition (RD); Social Work (SW); Respiratory Therapy (RT); Clinician/Case Coordinators; Pharmacy; Chaplaincy/Pastoral Care • Specialized nursing services (e.g. wound care, pain and symptom management/palliative team, home TPN team, stoma care) • Consult services available include: Psychiatry, lymphoedema specialists • Assessment of rehabilitation needs.² The rehabilitation needs of all patients should be assessed throughout the cancer pathway and particularly at times that present patients and caregivers with increased challenges.³ Note: An appropriate rehab goal of patients with a poor prognosis may be related to facilitating a return home for end-of-life care. • For patients with rehab potential, rehab is initiated and education is provided to patients and families regarding rehab deficits, rehab goals etc. • In preparation for transfer to rehab, discharge planning for reintegration into the community is initiated. This may include discussion around advanced care planning with the patient and family.
Specialization vs. Non-Specialization	<ul style="list-style-type: none"> • Patients should have access to the full complement of specialized oncology care providers and consult services regardless of whether the patient is located on an oncology-specific unit or on another type of specialized unit (i.e. orthopaedics, neurosurgery etc.)
Differentiating Criteria	<ul style="list-style-type: none"> • Rehab professionals assess and initiate rehab for patients who show some level of rehabilitation potential with identifiable goals as determined by the patient/team (e.g. Patients with a Palliative Performance Score \geq 40%). • Note: An appropriate rehab goal of patients with a poor prognosis may be related to facilitating a return home for end-of-life care.
Typical Duration	<ul style="list-style-type: none"> • Until discharged home, accepted into alternate level of care or shows evidence of no rehab potential
Key Activities/Nature of Service	<ul style="list-style-type: none"> • Focussed multi-disciplinary assessment to determine breadth of deficits and rehab intensity required; rehab is initiated, education provided to patient and family regarding rehab deficits, rehab goals etc. • Frequency of therapist involvement varies from 1 – 2 times a day to weekly depending on staffing and patient need.

TRANSITIONAL CARE in Acute Care, CCC or LTC (awaiting discharge to rehab or home)

TRANSITIONAL CARE IS NOT APPROPRIATE FOR ONCOLOGY PATIENTS WITH REHAB POTENTIAL AND IDENTIFIED REHAB GOALS WHO ARE AWAITING TRANSFER TO INPATIENT REHAB.

- Rehab patients with a good prognosis whose primary rehab need is to address general deconditioning pre- or post-cancer surgery/treatment should be referred and transferred directly to a mixed rehab program. (See definitions for Inpatient Oncology Rehab)
- Rehab patients with multiple medical and rehab needs should be referred and transferred to a rehab program with a dedicated oncology team. (See definitions for Inpatient Oncology Rehab)
- Rehab patients with multiple medical and rehab needs who require a slower-paced rehab program for a longer duration to maximize rehab potential should be referred and transferred to an LTLD/slowstream rehab program. This may include rehab patients whose lower tolerance levels are as a result of undergoing chemotherapy treatment. (See definitions for Inpatient Oncology Rehab)

Oncology Rehab Definition Framework

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INPATIENT REHAB			
Inpatient Mixed Rehab Units in Acute Care and Rehab Hospitals	Inpatient Dedicated Interprofessional Oncology Rehab Team on a Mixed Unit or Dedicated Oncology Rehab Units in Acute Care and Rehab Hospitals		Inpatient Low Tolerance Long Duration Rehab in CCC and Rehab Hospitals
Inpatient Rehab: Suitable for individuals in need of an interprofessional rehab program who also require 24-hour hospital care.	Inpatient Rehab: Suitable for individuals in need of an interprofessional rehab program and who also require 24-hour hospital care.		LTLD Rehab: Suitable for individuals in need of an interprofessional rehab program who may also have a chronic/complex condition requiring 24-hour hospital care over an extended period of time and who are expected to benefit from low intensity, long duration rehab
<ul style="list-style-type: none"> • The rehabilitation needs of all patients should be assessed throughout the cancer pathway and particularly at times that present patients and caregivers with increased challenges.⁴ • All patients have timely access to rehab services when and where they need them.⁵ • The presence of metastatic disease or chemotherapy treatment should not delay admission to rehab⁶ provided by a dedicated interprofessional oncology rehab team if the patient is able to participate in rehab at least 3 days per week. The rehab program should provide flexibility to accommodate the scheduling of medical/treatment appointments. 			
<p>Note re: Palliative Care: Patients in palliative care units can benefit from rehab to improve or maintain functional abilities and independence and overall quality of life. For example, rehab intervention can result in improved transfer techniques, increased strength, less assistance for activities of daily living and better seating. Rehab may enable some patients to return home or to an alternate level of care.⁷</p>			
Names Typically Used	<ul style="list-style-type: none"> • General Rehabilitation or Medical Rehabilitation 	<ul style="list-style-type: none"> • Inpatient Oncology Rehab Program 	<ul style="list-style-type: none"> • LTLD rehab; Slow-Stream; Slow-to-Recover, Neuroactivation
Services Provided	<ul style="list-style-type: none"> • Intensive rehab program. • Expectation is that the program can provide a minimum of 120 minutes of therapy per day for 5-7 days per week. • Staffing ratios should support, at minimum, the amount of therapy recommended.⁸ • A interprofessional team provides 	<ul style="list-style-type: none"> • Intensive rehab program; however, the program is able to accommodate patients who may initially only be able to tolerate a minimum of 30 minutes sitting, unsupported, but will progress to participating in a full therapy program. • The general expectation is that the program can provide a minimum of 120 minutes of therapeutic activity in total per day for 5-7 days per week. • Staffing ratios should support, at minimum, the amount of therapy recommended.⁹ 	<ul style="list-style-type: none"> • Low to moderately intensive rehab program where the program is able to accommodate patients who initially may only be able to tolerate 30 minutes of therapeutic activity per day. • Expectation is that the program can provide a minimum of 5 hours of therapy per week. • Staffing ratios should support at minimum, the amount of therapy recommended.¹⁴ • An interprofessional team provides rehab.

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<p style="text-align: center;">Inpatient Rehab:</p> <p>Suitable for individuals in need of an interprofessional rehab program who also require 24-hour hospital care.</p>	<p style="text-align: center;">Inpatient Rehab:</p> <p>Suitable for individuals in need of an interprofessional rehab program and who also require 24-hour hospital care.</p>	<p style="text-align: center;">LTLD Rehab:</p> <p>Suitable for individuals in need of an interprofessional rehab program who may also have a chronic/complex condition requiring 24-hour hospital care over an extended period of time and who are expected to benefit from low intensity, long duration rehab</p>
<p>rehab.</p> <ul style="list-style-type: none"> ● Core team* includes: Physician, Nurse, Physiotherapist, Occupational Therapist, Social Worker, Pharmacist, Speech-Language Pathologist, Clinical Dietician, Therapeutic Recreation Therapist and Chaplain/ Pastoral Care. ● Services may be supplemented by OTA/PTA/CDA/PSW[±] under the direct supervision of respective health care professionals (e.g., OT directing OTA, PT directing PTA, etc.) as legislated by their respective colleges. Assistants can provide support to the therapists, but the overall care is directed by the regulated health professional and the OTA/PTA/CDA/PSW usually does not exceed 50% of therapy time) 	<ul style="list-style-type: none"> ● The rehab program provides flexibility to allow for the higher incidence of medical complications in this patient population and associated modifications in goals.¹⁰ ● A dedicated interprofessional oncology rehab team provides rehab ● Core team** typically includes¹¹ <ul style="list-style-type: none"> ○ Physician ○ Nurse ○ Physiotherapist ○ Occupational Therapist ○ Social Worker ○ Pharmacist ○ Speech-Language Pathologist ○ Clinical Dietician ○ Therapeutic Recreation Specialist ○ Chaplain/Pastoral Care ● The core team works collaboratively with the patient's oncologist regarding ongoing cancer treatment and care 	<ul style="list-style-type: none"> ● Core team* includes: Physician, Nurse, Physiotherapist, Occupational Therapist, Social Worker, Pharmacist, Speech-Language Pathologist, Clinical Dietician, Therapeutic Recreation Specialist and Chaplain/ Pastoral Care. ● The core team works collaboratively with the patient's oncologist regarding ongoing cancer treatment and care management. ● Services may be supplemented by OTA/PTA/CDA/PSW[±] under the direct supervision of respective health care professionals (e.g., OT directing OTA, PT directing PTA, etc.) as legislated by their respective colleges. Assistants can provide support to the therapists, but the overall care is directed by the regulated health professional and the OTA/PTA/CDA/PSW usually does not exceed 50% of therapy time) ● Services available on consultation** as required¹⁵ are

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

[±] OTA=Occupational Therapy Assistant; PTA=Physiotherapist Assistant; CDA=Communication Disorders Assistant; PSW=Personal Support Worker

** Consultation would be expected to be available within 48 hours.

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<p style="text-align: center;">Inpatient Rehab: Suitable for individuals in need of an interprofessional rehab program who also require 24-hour hospital care.</p>	<p style="text-align: center;">Inpatient Rehab: Suitable for individuals in need of an interprofessional rehab program and who also require 24-hour hospital care.</p>	<p style="text-align: center;">LTLTD Rehab: Suitable for individuals in need of an interprofessional rehab program who may also have a chronic/complex condition requiring 24-hour hospital care over an extended period of time and who are expected to benefit from low intensity, long duration rehab</p>
	<p>management.</p> <ul style="list-style-type: none"> ● Services may be supplemented by OTA/PTA/CDA/PSW[‡] under the direct supervision of respective health care professionals (e.g., OT directing OTA, PT directing PTA, etc.) as legislated by their respective colleges. Assistants can provide support to the therapists, but the overall care is directed by the regulated health professional and the OTA/PTA/CDA/PSW usually does not exceed 50% of therapy time) ● Services available on consultation[†] as required¹² are available on site or arranged with an external provider. These may include: <ul style="list-style-type: none"> ○ Lymphoedema therapists ○ Stoma therapists ○ Oral health specialists ○ Psychosexual counsellors ○ Psychology/Psychiatry ○ Therapy Radiographers ● Assessment and treatment are provided focussing on functional ability, co-morbid diseases, psychosocial and spiritual issues, symptom management, bowel/bladder functioning, skin care and nutrition.¹³ ● The rehab goal of patients may be related to facilitating the 	<p>available on site or arranged with an external provider. These may include:</p> <ul style="list-style-type: none"> ○ Lymphoedema therapists ○ Stoma therapists, ○ Oral health specialists ○ Psychosexual counsellors ○ Psychology/Psychiatry ○ Therapy Radiographers ● Assessment and treatment are provided focussing on functional ability, co-morbid diseases, psychosocial and spiritual issues, symptom management, bowel/bladder functioning, skin care and nutrition.¹⁶ ● The program is able to address, through direct intervention or consultative services, related co-morbidities and complexities in the oncology rehab population (e.g. CNS related diagnoses such as spinal cord injury, brain injury) ● Administration of the following is provided: <ul style="list-style-type: none"> ○ TPN ○ Tube feeding ○ Oxygen ○ Suctioning

[†] Consultation would be expected to be available within 48 hours.

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	<p>return home for end-of-life care</p> <ul style="list-style-type: none"> ● The program is able to address, through direct intervention or consultative services, related co-morbidities and complexities in the oncology rehab population (e.g. CNS related diagnoses such as spinal cord injury, brain injury) ● Administration of the following is provided: <ul style="list-style-type: none"> ○ TPN ○ Tube feeding ○ Oxygen ○ Suctioning ○ Corked tracheostomies ○ Central Venous Access (i.e. PICC, Portacath, Hickman) ○ Continuous infusion and/or oral chemotherapies ○ VAC therapy ● Patients are supported to participate in as much therapy as is appropriate to their needs and as they are able to tolerate (i.e. there is flexibility around the scheduling of therapy sessions to accommodate external treatment appointments, fatigue levels etc). 	<ul style="list-style-type: none"> ○ Corked tracheostomies ○ Central Venous Access (i.e. PICC, Portacath, Hickman) ○ Continuous infusion and/or oral chemotherapies ○ VAC therapy <ul style="list-style-type: none"> ● Patients are supported to participate in as much therapy as is appropriate to their needs and as they are able to tolerate (i.e. there is flexibility around the scheduling of therapy sessions to accommodate external treatment appointments, fatigue levels etc).

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Specialization vs. Non-Specialization	<ul style="list-style-type: none"> Rehab providers assess/ treat a variety of diagnostic/rehab population groups.* No dedicated interprofessional oncology rehab team 	<ul style="list-style-type: none"> The dedicated interprofessional team providing oncology rehab has expertise in cancer care rehab and access to education/training to develop and maintain the necessary skills and knowledge base.¹⁷ On a mixed unit, there is a critical mass of 6 beds within the unit to support the development and maintenance of clinical expertise among nursing, allied health, medical staff and the acquisition of special equipment/resources required to treat oncology patients. 		<ul style="list-style-type: none"> The interprofessional team has expertise in assessment and treatment of medical complexities/multi-system illness and co-morbid conditions seen in the oncology rehab population. 	
Differentiating Criteria	<ul style="list-style-type: none"> Admission to a mixed unit is suitable for patients whose primary rehab need is to address general deconditioning. The presence of metastatic disease, if it does not preclude participation, should not delay admission to rehab.¹⁸ Designated interprofessional team, including physician. 	<ul style="list-style-type: none"> Admission to a unit with a dedicated oncology interprofessional team is suitable for: <ul style="list-style-type: none"> Patients with multiple medical and rehab needs Patients whose life expectancy may be limited (i.e. Palliative Performance Scale¹⁹ score $\geq 40\%$) and whose rehab goals are to facilitate the return to home or to family for end of life care. The presence of metastatic disease or chemotherapy treatment should not delay admission to rehab²⁰ if the patient is able to participate in therapy at least 3 days per 		<ul style="list-style-type: none"> Patients with multiple medical and rehab needs who require a slower-paced rehab program for a longer duration to maximize rehab potential. This may include patients who are undergoing chemotherapy treatment 5 days per week. The presence of metastatic disease or chemo treatment (i.e. up to 5 times per week) should not delay admission to rehab²² if the patient is able to participate in therapy at least 3 days per week. Dedicated interprofessional team, including physician, 	

* People with specific injuries such as ABI, Stroke and Spinal Cord Injury should ideally be treated by a specialized rehab team/program. Refer to the population-specific rehab definitions frameworks for recommendations regarding admission to a mixed unit.

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<ul style="list-style-type: none"> • Coordinated team approach with regular, weekly team meetings/conferences to promote consistency in the treatment approach by reviewing the patient's care plan, treatment goals and progress. • Family/significant others are recognized as key to enabling client function and attainment of rehab goals and are included throughout the rehab process: <ul style="list-style-type: none"> ▶ Families/caregivers, with patient consent, are included in discussions around key treatment decisions ▶ Families (and patients) are encouraged to participate in team meetings ▶ Mechanisms for communication of goals and plans to patients and families/caregivers are established. 	<p>week.</p> <ul style="list-style-type: none"> • Patients who have undergone or are undergoing cancer surgery/treatment and whose rehab needs may stem from other diagnostic conditions (e.g. spinal cord, brain injury, amputee, musculoskeletal) should be referred to the type of rehab program that can address their primary rehab need with access to consultation services to address the secondary rehab need. • A coordinated team approach is used with regular weekly team meetings/conferences to promote consistency in the treatment approach by reviewing the patient's care plan, treatment goals, and progress.²¹ • Family/significant others are recognized as key to enabling client function and attainment of rehab goals and are included throughout the rehab process: <ul style="list-style-type: none"> ▶ Families/caregivers, with patient consent, are included in discussions around key treatment decisions ▶ Families (and patients) are encouraged to participate in team meetings ▶ Mechanisms for communication of goals and plans to patients and families/caregivers are established. • Geographically clustered beds and patient care teams • Expectation is that patients will either be discharged home or 	<p>with specialization in medical complexities/multi-system illness and co-morbid conditions</p> <ul style="list-style-type: none"> • Coordinated team approach with regular, weekly or bi-weekly team meetings/conferences depending on the medical complexity of the patient to promote consistency in the treatment approach by reviewing the patient's care plan, treatment goals and progress. • Family/significant others are recognized as key to enabling client function and attainment of rehab goals and are included throughout the rehab process: <ul style="list-style-type: none"> ▶ Families/caregivers, with patient consent, are included in discussions around key treatment decisions ▶ Families (and patients) are encouraged to participate in team meetings ▶ Mechanisms for communication of goals and plans to patients and families/caregivers are established. • Geographically clustered beds and patient care teams • The expectation is that patients will return to home or a community residential setting or to a higher tolerance rehab program following LTLTD rehab. • If a patient with rehab goals is able to tolerate 10 or more hours of therapy per week, it is recommended

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		to their preferred accommodation in the community.		that the patient be considered for transfer to a higher tolerance dedicated oncology rehab program, dependent on needs. Ideally, the higher tolerance rehab program should be located within the same organization to optimize the continuity of care.	
<ul style="list-style-type: none"> Geographically clustered beds and patient care teams Expectation is that patients will either be discharged home or to their preferred accommodation in the community. 		<ul style="list-style-type: none"> Patients are exempt from co-payment when located in CCC while the realistic goal for them remains returning to the community. 			
Typical Duration	<ul style="list-style-type: none"> 2-4 weeks; however, the length of stay is not constrained by a maximum duration, but is linked to the patient's needs and goals. 		<ul style="list-style-type: none"> 2-6 weeks; however, the length of stay is not constrained by a maximum duration, but is linked to the patient's needs and goals. 		<ul style="list-style-type: none"> Typical duration is usually 3-6 months; however, the length of stay is not constrained by a maximum duration, but is linked to the patient's needs and goals.
Key Activities / Nature of Service	<ul style="list-style-type: none"> The mixed rehab unit is appropriate for patients who require a non-specialized rehab program to address general deconditioning pre- and post-cancer surgery/treatment or during treatment (i.e. up to 3 times per week). The mixed rehab unit is suitable for individuals requiring an intensive interprofessional rehab program. Wellness-focussed education is 		<ul style="list-style-type: none"> Patients who would benefit most from the expertise of the dedicated oncology rehab team are those with multiple medical and rehab needs. The dedicated oncology rehab team provides assessment and treatment to address the physical, mild cognitive (i.e. patient is able to follow instructions and participate in therapy), psychosocial and spiritual consequences pre- and post-cancer surgery/treatment or during treatment (i.e. up to 3 times per week). The provision and timing of services provides the appropriate flexibility to accommodate off-site treatment and/or 		<ul style="list-style-type: none"> LTLTD rehab is suitable for individuals in need of an interprofessional rehab program, who require an extended period of rehab to maximize recovery. The rehab team provides assessment and treatment to address the physical, mild cognitive (i.e. patient is able to follow instructions and participate in therapy), psychosocial and spiritual consequences pre- and post-cancer surgery/treatment or during treatment (i.e. up to 5 times per week). Patients may also have a chronic and a complex condition that requires care over an extended period

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INPATIENT REHAB		
Inpatient Mixed Rehab Units in Acute Care and Rehab Hospitals	Inpatient Dedicated Interprofessional Oncology Rehab Team on a Mixed Unit or Dedicated Oncology Rehab Units in Acute Care and Rehab Hospitals	Inpatient Low Tolerance Long Duration Rehab in CCC and Rehab Hospitals
<p>Inpatient Rehab: Suitable for individuals in need of an interprofessional rehab program who also require 24-hour hospital care.</p>	<p>Inpatient Rehab: Suitable for individuals in need of an interprofessional rehab program and who also require 24-hour hospital care.</p>	<p>LTLT Rehab: Suitable for individuals in need of an interprofessional rehab program who may also have a chronic/complex condition requiring 24-hour hospital care over an extended period of time and who are expected to benefit from low intensity, long duration rehab</p>
<p>offered to provide health education, goal setting, behaviour change principles and practices to promote optimal health and wellbeing of the individual.</p> <ul style="list-style-type: none"> • Comprehensive discharge planning is provided to transition patients to specialized services and community support programs as needed. 	<p>consultations.</p> <ul style="list-style-type: none"> • Wellness-focussed education is offered to provide health education, goal setting, behaviour change principles and practices to promote optimal health and wellbeing of the individual.²³ • Comprehensive discharge planning is provided to transition patients to specialized services and community support programs as needed. 	<p>of time and who are expected to benefit from low intensity, long duration rehabilitation</p> <ul style="list-style-type: none"> • Wellness-focussed education is offered to provide health education, goal setting, behaviour change principles and practices to promote optimal health and wellbeing of the individual. • Comprehensive discharge planning is provided to transition patients to specialized services and community support programs as needed.

OUTPATIENT/AMBULATORY REHAB PROGRAMS		
<p>Single Service in Acute Care Hospitals, Rehab Hospitals and Community Health Centres/Clinics</p> <p>Suitable for individuals who are in need of an outpatient rehabilitation service in a single specialty area/profession. Services may include assessment only or assessment and treatment. Services may be provided during a one-time visit or multiple visits.</p>	<p>Dedicated or Mixed Population Interprofessional Team in Acute Care Hospitals, Rehab Hospitals and Community Health Centres/Clinics²⁴</p> <p>Suitable for individuals in need of an interprofessional rehab program</p>	<p>Wellness Focused Rehab Groups</p> <p>Groups offered in an outpatient setting. Groups offered may include short term transitional groups or longer term ongoing groups.</p>
<ul style="list-style-type: none"> • The rehabilitation needs of all patients should be assessed throughout the cancer pathway and particularly at times that present patients and caregivers with increased challenges.²⁵ • All patients have timely access to rehab services when and where they need them.²⁶ 		
<p>Names Typically Used</p>	<ul style="list-style-type: none"> • Usually Outpatient + profession (e.g. Outpatient Physiotherapy, Outpatient Occupational Therapy). • Outpatient + specialty area (e.g. Lymphoedema Clinic). 	<p>Day Treatment Program, General Rehab Day Hospital Program</p> <ul style="list-style-type: none"> • Self-Management Groups • Exercise Programs • Education Series
<p>Services Provided</p>	<ul style="list-style-type: none"> • Varies depending on specialty areas within institution. • Health professionals provide: <ol style="list-style-type: none"> a specialty service for a specific impairment or disability (e.g. gait, mobility, hearing) or general profession-specific assessment, treatment plan recommendations or implementation of treatment plan and/or referral to other service providers <p>Note: Specialty service may use an interprofessional approach.</p>	<ul style="list-style-type: none"> • Patients receive a minimum of 45 - 60 minutes of therapy per session. • Care is provided by a dedicated interprofessional team. • The rehab needs of oncology rehab patients may vary due to the wide ranging number of cancer diagnoses within this rehab population group. To meet the diversity of rehab needs, the oncology rehab patient should have access to the following rehab professionals as needed <ul style="list-style-type: none"> ○ Physician ○ Nurse ○ Physiotherapist ○ Occupational Therapist ○ Social Worker ○ Pharmacist ○ Speech-Language Pathologist ○ Clinical Dietician ○ Psychologist • Groups are led by an individual rehab provider or team of rehab specialists • Typically meet once or twice per week. • Classes offered may include education and/or an exercise program or a combination of both

Oncology Rehab Definition Framework

This framework applies to individuals who have rehab potential and identified rehab goals

OUTPATIENT/AMBULATORY REHAB PROGRAMS				
Single Service in Acute Care Hospitals, Rehab Hospitals and Community Health Centres/Clinics		Dedicated or Mixed Population Interprofessional Team in Acute Care Hospitals, Rehab Hospitals and Community Health Centres/Clinics ²⁴		Wellness Focused Rehab Groups
		<ul style="list-style-type: none"> ○ Psychiatrist 		
Specialization vs. Non-Specialization	<ul style="list-style-type: none"> ● Services are profession specific ● At a minimum, the health professional should have general knowledge about cancer diagnosis, prognosis, treatment and the recovery process 	<ul style="list-style-type: none"> ● The treatment team must have some expertise and knowledge about cancer diagnoses, prognosis, potential deficits and the recovery process following cancer treatment. This level of expertise is needed to inform the development of a rehab plan that best meets the varying functional and tolerance levels amongst oncology rehab patients as well as their other rehab needs. 	<ul style="list-style-type: none"> ● Groups focus on enhancing an individual's ability to cope with a particular disability or impairment 	
Differentiating Criteria	<ul style="list-style-type: none"> ● Patients are residing in the community with a specific rehab need which may be an impairment, performance, activity or participation issue that requires assessment and/or treatment by a health professional. ● Patients may not have required an inpatient rehab program or other outpatient rehab programs. ● Some patients may be discharged from an inpatient rehab program or from acute care and require ongoing rehab to achieve higher functional goals. ● Patients may be referred from acute care, rehabilitation, or family physicians or other health professionals working in the community. ● In some hospitals, the service is only available for patients of that institution and their physicians. ● Typically, these are community patients who are 	<ul style="list-style-type: none"> ● Suitable for patients already residing in the community who no longer need 24-hour hospital care. ● A coordinated interprofessional team approach is used to address the rehab needs of the patient. ● Regular team meetings/conferences held at least once a month to discuss the care plan ● Patients and families are encouraged to participate in team meetings and mechanisms for communication of goals and plans are established. 	<ul style="list-style-type: none"> ● These groups are led by professional rehab providers ● Groups are time-limited and goal-oriented to increase coping with an impairment or disability ● Groups are publicly funded through the healthcare system ● Typically, these are community patients who are responsible for arranging their own transportation to and from their outpatient appointments. 	

OUTPATIENT/AMBULATORY REHAB PROGRAMS				
Single Service in Acute Care Hospitals, Rehab Hospitals and Community Health Centres/Clinics		Dedicated or Mixed Population Interprofessional Team in Acute Care Hospitals, Rehab Hospitals and Community Health Centres/Clinics ²⁴		Wellness Focused Rehab Groups
	responsible for arranging their own transportation to and from their outpatient appointments.			
Typical Duration	<ul style="list-style-type: none"> Varies depending on the type of service/program. Specialty clinics may provide one or a few visits until the problem is resolved or managed. Other profession specific treatment programs may occur once or several times a week for 6 – 12 weeks or longer. 	<ul style="list-style-type: none"> The length of stay varies depending on the rehab needs of the patient Patients typically participate 1- 2 days per week There is a mechanism in place to support the re-entry of patients to service as needed. 	8 – 16 weeks	
Key Activities / Nature of Service	<ul style="list-style-type: none"> Specialized focused assessment and/or treatment to address a functional or psychological issue and to promote re-integration to normal living or to maximize functional level. 	<ul style="list-style-type: none"> Programs are responsive to individual patient needs and patient identified goals. Specialized focused assessments and treatments are provided to maximize or address functional issues and psychological functioning and to promote re-integration to normal living. The program is delivered in a group format or on an individual basis. 	<ul style="list-style-type: none"> Groups provide health education, goal setting, behaviour change principles and practices to promote health and wellbeing of the individual Secondary prevention may be offered. 	

Oncology Rehab Definition Framework

This framework applies to individuals who have rehab potential and identified rehab goals

COMMUNITY (Rehab is provided to client in home, school or work environment)		
Community – Single Service	Community Based – Dedicated Interprofessional Oncology RehabTeam	
NOTE: CCAC does not currently use this type of care model. Recommendations are provided below regarding the components of an interprofessional model of rehab.		
<ul style="list-style-type: none"> The rehabilitation needs of all patients should be assessed throughout the cancer pathway and particularly at times that present patients and caregivers with increased challenges.²⁷ All patients have timely access to rehab services when and where they need them.²⁸ 		
Names Typically Used	Community Care Access Centre (CCAC)	Examples: Outreach (Behavioural, Geriatric, School), ABI CCAC
Services Provided	<ul style="list-style-type: none"> May include Occupational Therapy, Physiotherapy, Speech-Language Pathology, Social Work, Nursing, Dietitian, Case Manager and consultation with physician (referring MD or family MD). Clients may receive more than one service. Rehab providers typically work as individual providers; however, communication with other health providers occurs on an as-needed basis. CCACs provide in-home rehab services through contracts with Provider Agencies and manage clients through a Case Management collaborative model. 	A dedicated interprofessional oncology rehab team would include the following: <ul style="list-style-type: none"> Interprofessional team: OT, PT, SLP, SW, Nursing, Dietitian, Case Manager, MD (i.e. patient’s primary care physician who may be an oncologist, family physician, palliative care physician). Access to consultation services from psychology/psychiatry, hospice, Interlink. Face-to-face co-ordinated team conferences are scheduled at least once during the treatment period. Consultation/collaboration among team members occurs via teleconference on an as needed basis Services may include assessments, individualized programs, brief interventions, consultative assistance, and educational sessions to parents, families and professionals.
Specialization vs. Non-Specialization	<ul style="list-style-type: none"> Health professionals have expertise in oncology management and oncology rehab, including an in-depth understanding of cognition and cognitive changes that can result from CNS tumours, radiation to the brain or head for head/neck cancers and “chemo brain” 	<ul style="list-style-type: none"> These programs are specialized to provide rehab to oncology rehab patients to reduce the impact of the disease process
Differentiating Criteria	<ul style="list-style-type: none"> Service is provided in the home for homebound clients or clients who are unable to access an outpatient/ambulatory rehab program (e.g. due to fatigue, lack of an appropriate program in an 	<ul style="list-style-type: none"> Clients are: <ol style="list-style-type: none"> Home-bound or have limited tolerance potential; and Require focused assessment, intervention or consultation within natural environment (e.g.

Oncology Rehab Definition Framework

This framework applies to individuals who have rehab potential and identified rehab goals

COMMUNITY (Rehab is provided to client in home, school or work environment)		
Community – Single Service		Community Based – Dedicated Interprofessional Oncology RehabTeam
	outpatient setting).	NOTE: CCAC does not currently use this type of care model. Recommendations are provided below regarding the components of an interprofessional model of rehab. home, school or work) <ul style="list-style-type: none"> • Dedicated interprofessional team uses a coordinated team approach. • The team has expertise in oncology management and rehab..
Typical Duration	<ul style="list-style-type: none"> • Varies depending on program. Typically 1-2 visits per week. • CCAC involvement typically offered for 6 – 12 weeks 	<ul style="list-style-type: none"> • Varies depending on program. Typically 1-2 visits per week. • CCAC involvement typically offered for 6 – 12 weeks
Key Activities/Nature of Service	<ul style="list-style-type: none"> • Assessments, treatment, discharge planning to community activities/services, including wellness programs, to support community reintegration 	<ul style="list-style-type: none"> • Assessments, treatment, consultation, discharge planning to community activities, including wellness programs, to support community reintegration.

ENDNOTES

- ¹ National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer, March 2004.
- ² Assessment of rehab needs should be integrated within radiation, surgical or medical oncology settings. Frymark, SL, Cancer Rehabilitation Services: The road to survivorship. Oncology Issues, Nov/Dec 1999.
- ³ National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer, March 2004.
- ⁴ National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer, March 2004.
- ⁵ National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer. March 2004.
- ⁶ Marciniak, CM, Sliwa, JA, Spill, G, Heinemann, AW, Semik, PT. Functional Outcome following Rehabilitation of the Cancer Patient. Arch Phys Med Rehabil Vol 77, January 1996.
- ⁷ Frank, C, Hobbs, NR, Steward, GI. Rehabilitation on Palliative Care Units: Case Discussion. Journal of Palliative Care 14:2. 1998.
- ⁸ Currently, there is no evidence-based literature to support the amount of staffing required.
- ⁹ Currently, there is no evidence-based literature to support the amount of staffing required.
- ¹⁰ Marciniak, CM, Sliwa, JA, Spill, G, Heinemann, AW, Semik, PT. Functional Outcome following Rehabilitation of the Cancer Patient. Arch Phys Med Rehabil Vol 77, January 1996; Frymark, SL. Seminars in Oncology Nursing, Vol. 8 (3); August, 1992.
- ¹¹ National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer, March 2004.
- ¹² National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer, March 2004.
- ¹³ Common impairments include: fatigue, deconditioning, cognitive impairments, hemiparesis or hemiplegia, cranial nerve deficits, neurogenic bowel and bladder involvement (Marciniak, CM, Sliwa, JA, Spill, G, Heinemann, AW, Semik, PT. Arch Phys Med Rehabil Vol 77, January 1996); poor nutritional intake, pain and in severe cases, pulmonary fibrosis secondary to cytotoxic drugs (Young, L. The importance of cancer rehabilitation. Cancer Nursing Practice, Vol 44 (3) April 2005.); sexual dysfunction (National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer, March 2004); (Frymark, SL. Seminars in Oncology Nursing, Vol. 8 (3); August, 1992.)
- ¹⁴ Currently, there is no evidence-based literature to support the amount of staffing required.
- ¹⁵ National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer, March 2004.
- ¹⁶ Common impairments include: fatigue, deconditioning, cognitive impairments, hemiparesis or hemiplegia, cranial nerve deficits, neurogenic bowel and bladder involvement (Marciniak, CM, Sliwa, JA, Spill, G, Heinemann, AW, Semik, PT. Arch Phys Med Rehabil Vol 77, January 1996); poor nutritional intake, pain and in severe cases, pulmonary fibrosis secondary to cytotoxic drugs (Young, L. The importance of cancer rehabilitation. Cancer Nursing Practice, Vol 44 (3) April 2005.); sexual dysfunction (National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer, March 2004); (Frymark, SL. Seminars in Oncology Nursing, Vol. 8 (3); August, 1992.)
- ¹⁷ National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer. March 2004.

¹⁸ Marciniak, CM, Sliwa, JA, Spill, G, Heinemann, AW, Semik, PT. Functional Outcome following Rehabilitation of the Cancer Patient. Arch Phys Med Rehabil Vol 77, January 1996.

¹⁹ The Palliative Performance Scale version 2 (PPSv2) tool is copyrighted to Victoria Hospice Society and replaces the first PPS published in 1996 [J Pall Care 9(4): 26-32 Programs may use PPSv2 with appropriate recognition. Available in electronic Word format by email request to judy.martell@caphealth.org. Correspondence should be sent to Medical Director, Victoria Hospice Society, 1900 Fort St, Victoria, BC, V8R 1J8, Canada

²⁰ Marciniak, CM, Sliwa, JA, Spill, G, Heinemann, AW, Semik, PT. Functional Outcome following Rehabilitation of the Cancer Patient. Arch Phys Med Rehabil Vol 77, January 1996.

²¹ Frymark, SL. Seminars in Oncology Nursing, Vol. 8 (3); August, 1992.

²² Marciniak, CM, Sliwa, JA, Spill, G, Heinemann, AW, Semik, PT. Functional Outcome following Rehabilitation of the Cancer Patient. Arch Phys Med Rehabil Vol 77, January 1996.

²³ Education on self-management strategies can help to reduce the severity of symptoms, decrease pain, increase sense of control, resourcefulness and life satisfaction. National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer. March 2004.

²⁴ Currently, there is no evidence in the literature that differentiates between a dedicated oncology interprofessional rehab team versus a mixed population interprofessional team in the outpatient/ambulatory setting.

²⁵ National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer, March 2004.

²⁶ National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer. March 2004.

²⁷ National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer, March 2004.

²⁸ National Institute for Clinical Excellence: Guidance on Cancer Services – Improving Supportive and Palliative Care for Adults with Cancer. March 2004.

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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
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Mandy McGlynn, Hillcrest Centre/Toronto Rehab

Charissa Levy, Executive Director, GTA Rehab Network
Judy Moir, Executive Director (Acting), GTA Rehab Network
Sue Balogh, Project Coordinator/Planner, GTA Rehab Network

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