SW LHIN Complex Continuing Care Eligibility Guidelines

Name: _____  HIN: _____
Referring site: _____  Date: _____

Definition: OHA defines Complex Continuing Care as a specialized program of care providing programs for medically complex patients whose condition requires a hospital stay, regular onsite physician care and assessment and active care management by specialized staff.

The patient must be medically complex with a stabilized disease process and predictable outcomes.

1. The patient will benefit from being in a complex continuing care unit and has a combination of multiple interacting and unpredictable chronic medical conditions, which require a skilled interdisciplinary team approach.
2. The patient requires a long term, progressive, goal-oriented plan of care to reach an optimal level of mental, physical, cognitive and/or social well being.
3. The patient and/or substitute decision maker has consented to treatment in the program and demonstrates a willingness and motivation to participate in the treatment program.
4. The patient is not able to be managed in the community by CCAC services, informal care givers and/or other community services, is not a candidate for LTC at this time.

Eligibility Criteria Checklist
- Is 18 years or older (pediatric population by exception only)  [ ] Yes  [ ] No
- Has a clear diagnosis and co-morbidities identified  [ ] Yes  [ ] No
- Is medically and surgically stable, i.e. all reasons for acute care stay have been stabilized  [ ] Yes  [ ] No
- Has completed all consults and diagnostic tests for the purposes of diagnosis and/or treatment of acute conditions  [ ] Yes  [ ] No
- Has acknowledged and addressed all abnormal laboratory values, as required  [ ] Yes  [ ] No
- Has no substance abuse and/or mental health issues, which would limit the patient’s ability to participate in the program, and does not demonstrate behaviours that could be harmful to themselves and/or others  [ ] Yes  [ ] No
- Has been screened for all infection control concerns  [ ] Yes  [ ] No
- Requires more than 3-4 hours of direct care per day, which is primarily delivered by an RN/RPN  [ ] Yes  [ ] No
- Has established functional goals, which are specific, measurable, realistic and timely.  [ ] Yes  [ ] No
- Has demonstrated the potential to tolerate one 30 minute session of therapy, up to 5 days per week  [ ] Yes  [ ] No

Eligible:  [ ] Yes  [ ] No  Priority Code (definitions on page 2): [ ]

Complex Care Referral Types (Referral Type definitions on page 2):
- Med. Complex  [ ]
- End of Life Care  [ ]
- Restorative Care  [ ]
- Behavioural Health  [ ]

Comments: _____

Signature of Assessor: _____  Date: _____
<table>
<thead>
<tr>
<th>Medically Complex</th>
<th>Behavioural Health</th>
<th>End of Life Care</th>
<th>Restorative Care</th>
</tr>
</thead>
</table>
| People with multiple medically complex Conditions, such as complex wounds, ALS, MS, bariatric or COPD who require unique programming. | People with dementia and challenging behaviours who require skilled interventions in a controlled environment to facilitate their transition to the appropriate level of care. | People with a life limiting illness who are at the end stage of that disease process and who require pain and symptoms management and skilled interventions delivered by an interprofessional team. This may include people who require chemotherapy as part of their treatment regime to maintain comfort  
   a) Life expectancy of <3 months  
   b) Patient is on an established treatment regime with a focus on pain and symptom management and end of life care  
   c) Social supports have been depleted or are no longer available  
   d) Palliative Performance Scale 50% or less  
   e) Patient may be experiencing complexities associated with the end stage of their disease including delirium, aggression, agitation etc. | People with a multiple medical and/or functionally complex condition(s) who are expected to benefit from low intensity, long duration interventions provided by an interprofessional team, with clearly articulated functional improvement goals that can be attained within the average length of stay  
   a) Min-mental state exam (MMSE) score of >16  
   b) Presence of significant physical/functional impairments  
   c) Physical tolerance that permits participation in programming  
   d) Goal to go home or to a retirement home. |

**Priority Code Definitions**

**Priority 1 “Crisis”** - the Patient’s needs can be met in Complex Care and requires immediate admission (within days, not weeks) as a result of a crisis arising from the patient’s condition or circumstances that puts them at significant safety risk if left in their current environment.

**Priority 2 “Readmission/Change in Stream”** - A current Complex Care patient who needs another Complex Care stream, or a previous Complex Care patient transferred out due to an acute episode and is now medically stable and needs to return to a Complex Care bed.

**Priority 3 “All Others”** - Patient eligible for Complex Care and does not meet the requirements for Priority 1 or 2.

<table>
<thead>
<tr>
<th>FACILITY CHOICES</th>
<th>RANK</th>
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<tbody>
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Definition: According to the World Health organization, Rehabilitation is a progressive, dynamic goal-oriented and often time- limited process, which enables an individual with impairment to identify and reach his/her optimal mental, physical, cognitive and/or social functional level.

1. The patient has sufficient cognitive skills to set and attain functional goals, demonstrate regular progress, and readily integrate new learning skills into daily life.
2. The patient requires access to inter-professional staff, where periodic changes to the care plan and ongoing re-definition of therapeutic goals are required.
3. The patient requires a progressive, goal-oriented plan of care to reach an optimal level of mental, physical, cognitive and/or social well-being.
4. The patient and/or substitute decision maker has consented to treatment in the program and demonstrates a willingness and motivation to participate in the rehabilitation program.
5. The patient is not able to be managed in the community by CCAC services, informal care givers and/or other community services, and is not a candidate for LTC at this time.
6. Active treatment that results in the patient’s frequent absences from the unit during the rehabilitation treatment session must not interfere with the patient’s ability to participate in the rehabilitation.

Eligibility Criteria Checklist

- Is 18 years or older (pediatric population by exception only)     □ Yes □ No
- Has a clear diagnosis and co- morbidities identified     □ Yes □ No
- Is medically and surgically stable, ie. all reasons for acute care stay have been stabilized and/or reached a plateau     □ Yes □ No
- Has completed all consults and diagnostic tests for the purposes of diagnosis or treatment of acute conditions     □ Yes □ No
- Has acknowledged and addressed all abnormal laboratory values, as required
- Has no substance abuse and/or mental health issues, which would limit the patient’s ability to participate in the program, and does not demonstrate behaviours that could be harmful to themselves and/or others
- Has been screened for all infection control concerns     □ Yes □ No
- Has established functional goals, which are specific, measurable, realistic and timely     □ Yes □ No
- Is able to sit for 1 hour, 2-3 times per day, and tolerate 2 therapies per day     □ Yes □ No
- Is committed to returning to the community, utilizing family and/or community support services, as required
- Has a documented discharge destination     □ Yes □ No
- Has a follow-up plan in place at the time of referral, and follow-up appointments scheduled by the acute site at the time of discharge
- Has determined special equipment needs     □ Yes □ No

Eligible: □ Yes □ No

Priority Code (definitions on page 2):

Comments: ______

Signature of Assessor: ___________________________ Date: ______________________
**Priority Code Definitions**

**Priority 1 “Crisis”** - the Patient’s needs can be met in Rehabilitation and requires immediate admission (within days, not weeks) in order to optimize Rehab outcomes. This includes Acute Stroke patients.

**Priority 2 “Readmission/Change in Stream”** - A current Rehabilitation patient who needs another Rehabilitation stream, or a previous Rehabilitation patient transferred out due to an acute episode and is now medically stable and needs to return to a Rehabilitation bed.

**Priority 3 “All Others”** - Patient eligible for Rehabilitation and does not meet the requirements for Priority 1 or 2.

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<th>FACILITY CHOICES</th>
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Acute Care to Rehab & Complex
Continuing Care (CCC) Referral

Identify Referral Destination:  
☐ Referral to Rehab
☐ Referral to Complex Continuing Care (CCC)

If Faxed Include Number of Pages (Including Cover): _________ Pages

Estimated Date of Rehab/CCC Readiness: DD/MM/YYYY

<table>
<thead>
<tr>
<th>Patient Details and Demographics</th>
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<tr>
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<td>Gender: M F Other:</td>
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<tr>
<td>Marital Status:</td>
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<tr>
<td>Patient Speaks/Understands English: Yes No Interpreter Required: Yes No</td>
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<td>Primary Language: English French Other</td>
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<td>Primary Alternate Contact Person:</td>
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<td>Relationship to Patient: POA SDM Spouse Other</td>
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<td>Secondary Alternate Contact Person:</td>
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<td>Relationship to Patient: POA SDM Spouse Other</td>
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<td>Current Location Contact Number:</td>
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<tr>
<td>Bed Offer Contact (Name):</td>
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<tr>
<td>Bed Offer Contact Number:</td>
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</tr>
</tbody>
</table>
### Medical Information

**Primary Health Care Provider (e.g. MD or NP)**
- Surname: 
- Given Name(s): 

**Reason for Referral:**

**Allergies:**
- [ ] No Known Allergies
- [ ] Yes --- If Yes, List Allergies:

**Infection Control:**
- [ ] None
- [ ] MRSA
- [ ] VRE
- [ ] CDIFF
- [ ] ESBL
- [ ] TB
- [ ] Other (Specify): __________________________

**Admission Date:** DD/MM/YYYY  
**Date of Injury/Event:** DD/MM/YYYY  
**Surgery Date:** DD/MM/YYYY

### Rehab Specific

**Patient Goals:**

### CCC Specific

**Patient Goals:**

**Nature/Type of Injury/Event:**

**Primary Diagnosis:**

**History of Presenting Illness/Course in Hospital:**

**Current Active Medical Issues/Medical Services Following Patient:**

**Past Medical History:**

**Height:**  
**Weight:**

**Is Patient Currently Receiving Dialysis:**
- [ ] Yes
- [ ] No
- [ ] Peritoneal
- [ ] Hemodialysis
**Frequency/Days:** __________________________
**Location:** __________________________

**Is Patient Currently Receiving Chemotherapy:**
- [ ] Yes
- [ ] No
**Frequency:** __________________________  
**Duration:** __________________________
**Location:** __________________________
<table>
<thead>
<tr>
<th>ALC RM&amp;R BTI Patient Identification</th>
</tr>
</thead>
</table>

**Is Patient Currently Receiving Radiation Therapy:**
- Yes  
- No  

**Frequency:** ____________________  

**Duration:** ____________________

**Location:** ________________

**Concurrent Treatment Requirements Off-Site:**
- Yes  
- No  

**Details:** ________________

**CCC Specific**

**Medical Prognosis:**
- Improve  
- Remain Stable  
- Deteriorate  
- Palliative  
- Unknown  

**Palliative Performance Scale:** __________

**Services Consulted:**
- PT  
- OT  
- SW  
- Speech and Language Pathology  
- Nutrition  
- Other  ________________

**Pending Investigations:**
- Yes  
- No  

**Details:** ________________

**Frequency of Lab Tests:** ________________  

- Unknown  
- None

## Respiratory Care Requirements

**Does the Patient Have Respiratory Care Requirements?:**
- Yes  
- No  

**-- If No, Skip to Next Section**

**Supplemental Oxygen:**
- Yes  
- No

**Ventilator:**
- Yes  
- No

**Breath Stacking:**
- Yes  
- No

**Insufflation/Exsufflation:**
- Yes  
- No

**Tracheostomy:**
- Yes  
- No  
- Cuffed  
- Cuffless

**Suctioning:**
- Yes  
- No  

**Frequency:** ________________

**C-PAP:**
- Yes  
- No  

**Patient Owned:**
- Yes  
- No

**Bi-PAP:**
- Yes  
- No  

**Rescue Rate:**
- Yes  
- No  

**Patient Owned:**
- Yes  
- No

**Additional Comments:**

## IV Therapy

**IV in Use?:**
- Yes  
- No  

**-- If No, Skip to Next Section**

**IV Therapy:**
- Yes  
- No

**Central Line:**
- Yes  
- No

**PICC Line:**
- Yes  
- No

## Swallowing and Nutrition

**Swallowing Deficit:**
- Yes  
- No  

**Swallowing Assessment Completed:**
- Yes  
- No

**Type of Swallowing Deficit Including any Additional Details:**

**TPN:**
- Yes (If Yes, Include Prescription With Referral)  
- No

**Enteral Feeding:**
- Yes  
- No
### Skin Condition

**Surgical Wounds and/or Other Wounds Ulcers:**
- Yes
- No -- If No, Skip to Next Section

1. **Location:**
   - Stage:
   - Dressing Type:
     - (e.g. Negative Pressure Wound Therapy or VAC)
   - Frequency:
   - Time to Complete Dressing:
     - Less Than 30 Minutes
     - Greater Than 30 Minutes

2. **Location:**
   - Stage:
   - Dressing Type:
     - (e.g. Negative Pressure Wound Therapy or VAC)
   - Frequency:
   - Time to Complete Dressing:
     - Less Than 30 Minutes
     - Greater Than 30 Minutes

3. **Location:**
   - Stage:
   - Dressing Type:
     - (e.g. Negative Pressure Wound Therapy or VAC)
   - Frequency:
   - Time to Complete Dressing:
     - Less Than 30 Minutes
     - Greater Than 30 Minutes

*If additional wounds exist, add supplementary information on a separate sheet of paper.*

### Continence

**Is Patient Continent?:**
- Yes
- No -- If Yes, Skip to Next Section

- **Bladder Continent:**
  - Yes
  - No
  - If No:
    - Occasional Incontinence
    - Incontinent

- **Bowel Continent:**
  - Yes
  - No
  - If No:
    - Occasional Incontinence
    - Incontinent

### Pain Care Requirements

**Does the Patient Have a Pain Management Strategy?:**
- Yes
- No -- If No, Skip to Next Section

- **Controlled With Oral Analgesics:**
  - Yes
  - No

- **Medication Pump:**
  - Yes
  - No

- **Epidural:**
  - Yes
  - No

- **Has a Pain Plan of Care Been Started:**
  - Yes
  - No

### Communication

**Does the Patient Have a Communication Impairment?:**
- Yes
- No -- If No, Skip to Next Section

- **Communication Impairment Description:**

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### Patient Identification

#### Cognition

<table>
<thead>
<tr>
<th>Cognitive Impairment:</th>
<th>□ Yes</th>
<th>□ No</th>
<th>□ Unable to Assess -- If No, or Unable to Assess, Skip to Next Section</th>
</tr>
</thead>
</table>

Details on Cognitive Deficits:

- Has the Patient Shown the Ability to Learn and Retain Information: □ Yes □ No -- If No, Details:

- Delirium: □ Yes □ No -- If Yes, Cause/Details:

- History of Diagnosed Dementia: □ Yes □ No

#### Behaviour

<table>
<thead>
<tr>
<th>Are There Behavioural Issues:</th>
<th>□ Yes</th>
<th>□ No -- If No, Skip to Next Section</th>
</tr>
</thead>
</table>

- Does the Patient Have a Behaviour Management Strategy?: □ Yes □ No

- Behaviour:
  - □ Need for Constant Observation
  - □ Verbal Aggression
  - □ Physical Aggression
  - □ Agitation
  - □ Wandering
  - □ Sun downing
  - □ Exit-Seeking
  - □ Resisting Care
  - □ Other

- □ Restraints -- If Yes, Type/Frequency Details:

- Level of Security:
  - □ Non-Secure Unit
  - □ Secure Unit
  - □ Wander Guard
  - □ One-to-one

#### Social History

- Discharge Destination:
  - □ Multi-Storey
  - □ Bungalow
  - □ Apartment
  - □ LTC
  - □ Retirement Home (Name):

- Accommodation Barriers: □ Unknown

- Smoking: □ Yes □ No Details:

- Alcohol and/or Drug Use: □ Yes □ No Details:

- Previous Community Supports: □ Yes □ No Details:

- Discharge Planning Post Hospitalization Addressed: □ Yes □ No Details:

- Discharge Plan Discussed With Patient/SDM: □ Yes □ No
### Current Functional Status

**Sitting Tolerance:**
- [ ] More Than 2 Hours Daily
- [ ] 1-2 Hours Daily
- [ ] Less Than 1 Hour Daily
- [ ] Has not Been Up

**Transfers:**
- [ ] Independent
- [ ] Supervision
- [ ] Assist x1
- [ ] Assist x2
- [ ] Mechanical Lift

**Ambulation:**
- [ ] Independent
- [ ] Supervision
- [ ] Assist x1
- [ ] Assist x2
- [ ] Unable

**Number of Metres:** ______________

**Weight Bearing Status:**
- [ ] Full
- [ ] As Tolerated
- [ ] Partial
- [ ] Toe Touch
- [ ] Non

**Bed Mobility:**
- [ ] Independent
- [ ] Supervision
- [ ] Assist x1
- [ ] Assist x2

### Activities of Daily Living

#### Level of Function Prior to Hospital Admission (ADL & IADL):

**Current Status – Complete the Table Below:**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Cueing/Set-up or Supervision</th>
<th>Minimum Assist</th>
<th>Moderate Assist</th>
<th>Maximum Assist</th>
<th>Total Care</th>
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<tbody>
<tr>
<td>Eating:</td>
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<td>(Ability to feed self)</td>
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<td>Grooming:</td>
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<tr>
<td>(Ability to wash face/hands, comb hair, brush teeth)</td>
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<td>Dressing:</td>
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<td>Toileting:</td>
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<tr>
<td>(Ability to self-toilet)</td>
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<tr>
<td>(Ability to wash self)</td>
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</table>
### Special Equipment Needs

- **Special Equipment Required:** □ Yes □ No -- If No, Skip to Next Section

- □ HALO
- □ Orthosis
- □ Bariatric
- □ Other

- **Pleuracentesis:** □ Yes □ No
- **Need for a Specialized Mattress:** □ Yes □ No

- **Paracentesis:** □ Yes □ No
- **Negative Pressure Wound Therapy (NPWT):** □ Yes □ No

### Rehab Specific

**AlphaFIM® Instrument**

- **Is AlphaFIM® Data Available:** □ Yes □ No -- If No, Skip to Next Section

- **Has the Patient Been Observed Walking 150 Feet or More:** □ Yes □ No

#### If Yes – Raw Ratings (levels 1-7):

- Transfers: Bed, Chair
- Expression
- Transfers: Toilet
- Bowel Management
- Locomotion: Walk
- Memory

#### If No – Raw Ratings (levels 1-7):

- Eating
- Expression
- Transfers: Toilet
- Bowel Management
- Grooming
- Memory

#### Projected:

- FIM® projected Raw Motor (13):
- FIM® projected Cognitive (5):

#### Help Needed:

### Attachments

**Details on Other Relevant Information That Would Assist With This Referral:**

Please Include With This Referral:

- □ Admission History and Physical
- □ Relevant Assessments (Behavioural, PT, OT, SLP, SW, Nursing, Physician)
- □ All relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US etc.)
- □ Relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology and any Psychologist or Psychiatrist Consult Notes if Behaviours are Present)

### Completed By:

**Contact Number:**

**Title:**

**Date:** DD/MM/YYYY

**Direct Unit Phone Number:**

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