Rehabilitative Care Alliance

Operationalization and Impact of RCA Deliverables

RCA Deliverables*

- RCA Definitions Framework
- RCA Capacity Planning Framework
- RCA Rehabilitative Care System Evaluation Framework
- RCA OP/AMB Rehabilitative Care Minimum Data Set
- RCA Capacity Planning Framework
- RCA Definitions Framework
- RCA Process to Support High Risk Adults to Access Rehabilitative Care Beds Directly from the Community/ED
- RCA Frail Senior/Medically Complex Compendium
- RCA PCRC Toolkit
- RCA Rehabilitative Care System Evaluation Framework

Steps to Implement RCA Deliverables

1. Align each local rehabilitative care program within a level of rehabilitative care from the **RCA Definitions Framework**
2. Complete analysis of current state rehabilitative care system resources:
   - In consideration of the RCA Definitions Framework (e.g. Do current program goals and/or target populations served need to be re-defined? Do the current allied health/nursing/medical resources meet the definitions?)
   - As per measures described within the **RCA Capacity Planning Framework** (e.g. Describe current utilization of existing rehabilitative care system resources. What rehabilitative care services are being accessed outside of your LHIN? Which populations are accessing these services and why? What rehab-sensitive populations are currently not being served and why?
   - In consideration of current performance on indicators described within the **RCA Rehabilitative Care System Evaluation Framework** (e.g. what is the current performance of the local rehabilitative care system compared to provincial targets/benchmarks

Note: This current state analysis will in part be informed by data collected as per the **RCA OP/AMB Rehabilitative Care Minimum Data Set (MDS)** (once implemented) as well as other existing reporting tools.

3. Design a desired future state that:
   - Uses measures described within the **RCA Capacity Planning Framework**
   - Supports required resourcing and equitable geographic distribution of each level of rehabilitative care as per the **RCA Definitions Framework**.
   - Supports **High Risk Adults to Access Rehabilitative Care Beds Directly from the Community/ED**

Note: The **RCA Frail Senior/Medically Complex Compendium** has been designed to support rehabilitative care providers across the continuum to identify & manage the geriatric syndromes that contribute to frailty.

4. If achievement of the desired future state requires consideration of the reclassification of CCC/Rehab Beds, consult the **RCA PCRC Toolkit**

5. Evaluate the effect of changes as per local performance relative to the **RCA Rehabilitative Care System Evaluation Framework**

Value and Impact

The RCA Definitions Framework will:

- Establish provincial standards for rehabilitative levels of care across the continuum
- Provide clarity for patients, families and referring professionals on the focus and clinical components of rehabilitative care programs
- Provide a foundation to support system and local capacity planning through a common understanding of rehabilitative care services

The **RCA Capacity Planning Framework** describes a standardized approach to rehabilitative care system planning within and across LHINs.

The **RCA Evaluation Framework** can be used to identify priority areas for improvement (based on current performance on key rehabilitative care and health system indicators) to ensure the future state design includes strategies to address performance gaps.

Implementation of the **RCA OP/AMB Rehabilitative Care MDS** will provide missing critical information regarding the utilization, availability, delivery, quality and value of outpatient rehabilitative care services and will inform the development of emerging post-acute QBPs

Implementation of the process to admit **High Risk Adults to Access Rehabilitative Care Beds Directly from the Community/ED** will eliminate acute care as the sole access point to rehabilitative care beds and is expected to reduce the number of avoidable acute care admissions that are discharged to rehab (e.g. 2-Day ALC, "Failure to Thrive") as these patients will be admitted to rehabilitative care directly from the community.

The **RCA Frail Senior/Medically Complex Compendium** is a knowledge translation tool that will support the delivery of Assess & Restore interventions across the care continuum. The Compendium will support the development of capability across rehabilitative care services to identify and manage the geriatric syndromes that contribute to frailty. This will support the development of geriatric expertise to optimize use of geriatrician/SGS resources.

The **RCA PCRC Toolkit** will support a standardized provincial approach to support LHINs and Health Service Providers (HSPs) to complete due diligence when considering the re-classification of Complex Continuing Care (CCC) and Inpatient Rehabilitation beds once a potential need for re-classification is identified

The **RCA Evaluation Framework** includes existing key indicators to support evaluation of system performance and prioritization of regional and provincial quality improvement opportunities. The evaluation framework will also support demonstration of the contribution of the rehabilitative care system to overall health care system objectives

Related System Initiatives

- Health System Funding Reform
- 2013 Auditor General Report
- Ontario's Senior Strategy / Assess & Restore
- Coordinated Access (where applicable)
- Provincial Referral Standards
- Physiotherapy Reform

*All deliverables to be available in April 2015, except the RCA Bedded Definitions Framework and the RCA PCRC Toolkit which were endorsed and disseminated in December 2014 and January 2015, respectively.

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