Driving System Change

2017-2019 Report
Evidence shows that rehabilitative care improves health outcomes, shortens hospital stays and helps older adults to maintain function and avoid hospitalization.

Today, these benefits take on added importance as health service providers seek to improve flow, divert patients from emergency departments and reduce hallway medicine.

The Rehabilitative Care Alliance (RCA) has already set in motion the necessary change to achieve these results. Working in collaboration with provincial stakeholders, the RCA is standardizing many aspects of planning, evaluation and clinical care across the province to ensure that rehabilitative care resources are used more efficiently and effectively, that capacity across the system is increased and that Ontarians receive the high quality rehabilitative care they need.

The work is complex; it requires openness to change and a strong commitment to working together. The RCA was established just six years ago, yet in this short period we have made remarkable progress on standardizing care across the province, implementing evidence-based rehabilitative care, introducing provincial benchmarks and reporting performance against them. The work of the RCA is also broad; we continue to lay the foundation for system-wide improvements across all regions and rehab populations to support equity in care provision.

All of this has been made possible by the collective effort of the LHINs, health service providers and patients and caregivers. As the RCA begins another three-year mandate (April 1, 2019 – March 31, 2022), we want to express our gratitude to the more than 350 individuals from across the province who participate in our task and advisory groups, supported by our small and dedicated secretariat. Thank you for your continued support.

We are proud of what the RCA has accomplished to date and look forward to our continued efforts as we create system change together.

Donna Cripps      Dr. Peter Nord
Co-Chair      Co-Chair
RCA Steering Committee    RCA Steering Committee
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Executive Summary

The benefits of rehabilitation are clear: better health outcomes, reduced health care costs and improved quality of life.

But achieving these benefits will require better planning, performance management and evaluation across all rehabilitation services. Best practices must also be integrated into rehabilitative care across the entire care continuum.

The Rehabilitative Care Alliance (RCA) was created by Ontario’s Local Health Integration Networks (LHINs) in 2013 to take on this challenge and bring about the system transformation that no single LHIN could achieve on its own. Today, the RCA has set in motion significant change across the province with the support of LHINs, health service providers (HSPs), subject matter experts and patient and family representatives. By standardizing many aspects of planning, evaluation and clinical care across the province, the RCA and its partners are ensuring that health care resources are used more effectively and that Ontarians receive high quality rehabilitative care no matter where they live.

IMPACT THROUGH COLLABORATIVE ACTION

The growing and cumulative impact of RCA initiatives is reflected in the following areas:

- **Standardizing rehabilitative care best practices for frail older adults**
  The RCA’s new evidence-based care pathways will make it easier for primary care and emergency departments (EDs) to connect older patients who have fallen with rehabilitative services that prevent functional decline and secondary falls. By reducing falls, the pathways will address one of the leading causes of preventable injuries among Ontario seniors that result in ED visits and hospitalizations.

- **Implementing standardized planning for future need**
  The RCA’s capacity planning framework and methodology provides regions with a simplified model to address local need now and in the future. The approach incorporates patient input, population data and various models of care to ensure that plans to address future rehabilitative care needs are efficient, cost-effective and evidence-informed.

- **Supporting standardized rehabilitative best practices for patients with hip fracture and total joint replacement**
  The RCA’s evidence-informed best practice frameworks for patients with hip fracture and total joint replacement (TJR) provide health service providers with detailed best practices to plan and deliver quality post-acute rehabilitative care. Using the RCA’s self-assessment process, HSPs have focused their quality improvement efforts to increase their alignment with the guidelines and enhance the quality and efficiency of the rehabilitative care they provide.
• **Improving quality through standardized evaluation of rehabilitative care services**

The RCA’s evaluation framework and annual system performance report define quality rehabilitative care and support system-wide improvement. Provincial benchmarks for rehabilitative care system indicators have been established in three priority areas for the first time: wait times for inpatient rehabilitative care, wait times for in-home rehabilitative care and repeat ED visits for falls for seniors aged 65 and over. LHINs also have information to assess their performance against each other and provincial benchmarks and to focus their efforts to improve quality and flow.

• **Implementing provincial standards for rehabilitative care programs**

The RCA’s definitions frameworks are leading to more consistent rehabilitative care for individuals across the province regardless of where they live or the organization providing their care. Improved clarity among referring providers about the level of services provided by each program supports more appropriate referrals and better transitions. LHINs and HSPs also have increased clarity about program resource requirements to support planning at the local and regional level.

• **Supporting Assess & Restore evaluation and knowledge translation**

The RCA’s annual report on the Assess & Restore (A&R) initiatives allows the LHINs to demonstrate their progress on implementing the A&R Guideline. The consistent approach to data collection and evaluation helps LHINs demonstrate the collective provincial impact of A&R funding and value for money.

• **Tracking performance outcomes for outpatient rehabilitation services**

A long-standing gap in data collection has been addressed and the value of outpatient rehabilitation within the health care system can now be demonstrated. Clinics across the province are able to gather standardized, comparable outpatient data using three data reporting tools, and the Ministry of Health and Long-Term Care (MOHLTC) has mandated use of one of the tools (NACRS Clinic Lite) in the hip and knee bundled funding pilot. Clinicians, planners and policy-makers are beginning to have access to meaningful outpatient data to inform planning and determine the efficacy of outpatient rehabilitation vs. other models of care.

As the RCA begins its new three-year mandate and work plan on April 1, 2019, it will continue to build on the progress of existing initiatives, while addressing emerging priorities within the health care system. Together with its stakeholders across the province, the RCA will continue to take collective, coordinated action to strengthen and standardize rehabilitative care and bring about system change.
Driving System Change

The benefits of rehabilitation are clear: better health outcomes, reduced health care costs and improved quality of life.

But achieving these benefits will require better planning, performance management and evaluation across all rehabilitation services. Best practices must also be integrated into rehabilitative care across the entire care continuum.

The Rehabilitative Care Alliance was created by Ontario’s LHINs in 2013 to take on this challenge and bring about the system transformation that no single LHIN could achieve on its own. Today, the RCA has set in motion significant change across the province with the support of LHINs, health service providers, subject matter experts and patient and family representatives. By standardizing many aspects of planning, evaluation and clinical care across the province, the RCA and its partners are ensuring that health care resources are used more effectively and that Ontarians receive high quality rehabilitative care no matter where they live.

This report details the RCA’s work over the last two years, all of which builds on the RCA’s previous achievements. The following summary provides an overview of the growing and cumulative impact of RCA initiatives:

IMPACT THROUGH COLLABORATIVE ACTION

Frail Seniors Initiative

Standardizing rehabilitative care practices for frail older adults

2017

Lack of clarity on the role of rehabilitative care services in preventing secondary falls among older adults.

Today

New evidence-based pathways to connect older adults who fall with rehabilitative care to prevent functional decline, additional falls and repeat hospitalizations.

The impact

The RCA’s care pathways will make it easier for primary care and emergency departments to connect older patients who have fallen with rehabilitative services that prevent functional decline and secondary falls. By reducing falls, the pathways will address one of the leading causes of preventable injuries among Ontario seniors that result in ED visits and hospitalizations.
RCA accomplishments to date

- Worked with the Regional Geriatrics Programs (RGPs) of Ontario and other provincial stakeholders to develop primary care and ED clinical care pathways.
- Engaged broad group of clinicians and RCA Patient/Caregiver Advisory Group to ensure pathways are practical and can be implemented.

### Capacity Planning Initiative
Implementing standardized planning for future need

<table>
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<tr>
<th>2013</th>
<th>Today</th>
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<tbody>
<tr>
<td>Each LHIN uses its own approach for capacity planning, resulting in duplicated effort and variable outcomes.</td>
<td>Standardized approach supports more consistent and efficient capacity planning across all regions.</td>
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The impact

The RCA’s capacity planning framework and methodology provides regions with a simplified model to address local need now and in the future. The approach incorporates patient input, population data and various models of care to ensure that plans to address future rehabilitative care needs are efficient, cost-effective and evidence-informed.

RCA accomplishments to date

- Developed a standardized capacity planning framework and methodology for extracting and analyzing data.
- Gathered and analyzed three years of LHIN data.
- Developed a simplified approach to implementing region-specific capacity planning (a Health System Structural Assessment approach) that addresses the rehabilitative care needs of patients and best practice models of care.
- Tested the approach for the post-hip fracture population.
- Provided toolkit to LHINs to create region-specific capacity plans.

### Hip Fracture/TJR QBP Best Practices Initiative
Supporting standardized rehabilitative best practices for patients with hip fracture and TJR

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<th>2013</th>
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The impact

The RCA frameworks provide HSPs with detailed best practices to plan and deliver quality post-acute rehabilitative care and support their efforts to implement the clinical handbooks, HQO’s *Quality Standard for Hip Fracture* and the MOHLTC’s hip and knee bundled funding pilot. Using the RCA’s self-assessment process, HSPs have focused their quality improvement efforts to increase their alignment with the guidelines and enhance the quality and efficiency of the rehabilitative care they provide.

RCA accomplishments to date

- Developed best practice frameworks for hip fracture and TJR populations with detailed best practices for rehabilitative care across the care continuum.
- Developed resources to support implementation by HSPs.
- Created self-assessment tools to help HSPs assess how well their current care aligns with best practices and provide them with immediate feedback to help them improve care.
- Recruited more than 100 organizations across 14 LHINs to participate in self-assessment.
- Analyzed results at regional and provincial level to allow LHINs and HSPs to compare their performance against provincial average and provide insights to concentrate their quality improvement (QI) efforts.

System Evaluation Initiative

**Improving quality through standardized evaluation of rehabilitative care services**

**2013**

No standardized, coordinated approach to evaluating rehabilitative care for all patient populations and across the continuum.

**Today**

Province-wide evaluation and annual reporting using standardized approach to indicators, data extraction, analysis and reporting.

The impact

The RCA’s evaluation framework and annual system performance report define quality rehabilitative care and support system-wide improvement. Provincial benchmarks for rehabilitative care system indicators have been established in three priority areas for the first time:

- Wait times for inpatient rehabilitative care.
- Wait times for in-home rehabilitative care.
- Repeat ED visits for falls for seniors aged 65 and over.

LHINs also have information to assess their performance against each other and provincial benchmarks and to focus their efforts to improve quality and flow.

RCA accomplishments to date

- Developed a shared framework for evaluating system performance.
- Defined performance indicators so data can be collected and reported in a standardized way.
- Established evidence-informed provincial benchmarks for three priority indicators.
• Developed interactive performance scorecard to allow easy comparison of data across regions.
• Released three annual reports on rehabilitative care provided across Ontario.
• Provided QI toolkit to LHINs, including process for root cause analysis and change ideas.

Definitions Initiative
Implementing provincial standards for rehabilitative care programs

2013
Lack of consistent eligibility criteria and clinical components among rehabilitative care programs and lack of clarity on which programs were appropriate for which patients.

Today
Clearly defined provincial standards for levels of bedded and community-based rehabilitative care are being implemented across Ontario to support planning, transitions and flow.

The impact
The RCA’s definitions frameworks are leading to more consistent rehabilitative care for individuals across the province regardless of where they live or the organization providing their care. Improved clarity among referring providers about the level of services provided by each program supports more appropriate referrals and better transitions. LHINs and HSPs have increased clarity about program resource requirements to support planning at the local and regional level.

RCA accomplishments to date
• Developed definitions frameworks for bedded and community-based rehabilitative care that define levels of care (including intensity of therapy, average length of stay and discharge indicators).
• Conducted comprehensive mapping survey and LHIN-specific analysis to determine alignment of existing programs.
• Developed tools and resources to help LHINs and HSPs implement the frameworks.
• Worked to address issues related to reporting mechanisms for rehabilitative care.
• Launched rehabcareontario.ca to provide LHIN-specific rehabilitative care information for the public and providers.

Outpatient Reporting Initiative
Tracking performance outcomes for outpatient rehabilitation services

2013
No system in place to collect standardized data on outpatient/ambulatory rehabilitative care.

Today
Minimum data set for outpatient/ambulatory rehabilitative care established and rollout across province underway.
The impact

A long-standing gap in data collection has been addressed and the value of outpatient rehabilitation within the health care system can now be demonstrated. Clinics across the province are able to gather standardized, comparable outpatient data using three data reporting tools and the MOHLTC has mandated use of one of the tools (NACRS Clinic Lite) in the hip and knee bundled funding pilot. Clinicians, planners and policy-makers are beginning to have access to meaningful outpatient data to inform planning and determine the efficacy of outpatient rehabilitation vs. other models of care.

RCA accomplishments to date

- Developed a rehabilitative care minimum data set to support standardized data collection and evaluation of outpatient rehabilitation.
- Conducted and evaluated provincial pilot of three data reporting tools: NACRS Clinic Lite (access and service utilization), WATLX™ (patient experience) and the Community Rehab Assessment (functional outcomes).
- Supported sites implementing NACRS Clinic Lite as part of the MOHLTC hip and knee bundled funding pilot.
- Revised Community Rehab Assessment tool and conducted a second pilot.

STAKEHOLDERS ASSESS THE RCA’S PERFORMANCE

From the beginning, the RCA’s strength has been its ongoing engagement with provincial stakeholders. This past year, the RCA conducted a survey to evaluate the impact of the RCA. More than 140 responded.

Stakeholders reported that the RCA’s population-specific clinical guidelines for rehabilitative care and system-focused frameworks are contributing to standardized care and that RCA frameworks and tools are making rehabilitative care more efficient and effective.

Respondents also pointed to the unique role the RCA plays at a provincial level. The majority said they regard the RCA as a provincial advisor for rehabilitative care and many noted that the RCA provides a provincial voice for rehabilitation. Stakeholders also suggested that the RCA is able to achieve results because it helps organizations move beyond their own interests to address issues collectively.

As the RCA begins to implement its next three-year work plan, it will continue to build on this successful collaborative model.
“The RCA has continued to raise the vital role of rehabilitation services in the continuum of high quality health care. As the system strives to address acute care capacity issues, rehabilitation services need to be capitalized upon to provide effective care after hospitalization and to support the community to prevent admissions where possible. The RCA is moving this agenda forward.”

Chris Sulway
Vice President, Quality, Performance & Accountability
Toronto Central LHIN
BACKGROUND

Since 2013, the RCA has led a number of initiatives focused on rehabilitative care approaches for frail seniors to help LHINs and HSPs implement the MOHLTC’s Assess & Restore Guideline. This work included developing and implementing a standardized process to support direct admissions to bedded levels of rehabilitative care from the community/ED (Direct Access Priority Process [DAPP]) and conducting an annual analysis of the impact of Assess & Restore initiatives.

More recently, the RCA’s focus has shifted to falls — a leading cause of preventable injury among older adults.\(^1\) Falls often result in emergency department visits and lengthy hospitalizations; in fact, the average length of stay due to falls is ten days longer than among seniors admitted for any cause.\(^2\) Furthermore, repeat falls are common. A recent RCA report found that 15 per cent of ED visits for falls for community-dwelling seniors 65 years and older were repeat visits.\(^3\)

Although some LHINs have developed fall prevention pathways as outlined in the province’s 2011 Integrated Provincial Falls Prevention Framework & Toolkit, many have not. As a result, there is no consistent and comprehensive approach to addressing secondary fall prevention across the province.

DELIVERABLES

The RCA’s focus for 2017–2019 was to standardize best practice rehabilitative care for frail older adults by developing secondary fall prevention care pathways. The RCA also continued to support evaluation and knowledge exchange for Assess & Restore-funded initiatives. The deliverables were as follows:

- Work with the Assess & Restore/Frail Senior Advisory Group, the RGPs of Ontario and other provincial stakeholders to develop and support implementation of secondary fall prevention care pathways for frail older adults.
- Hold annual Assess & Restore knowledge exchange events.
- Produce analysis and summary reports of the provincial impact of 2016/17 and 2017/18 Assess & Restore funding.
- Identify shared process and outcome indicators to support standardized evaluation and reporting across Assess & Restore-funded initiatives.

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• Complete geriatric-focused *Quality Standard Feasibility Analyses* in collaboration with the RGPs of Ontario and submit to Health Quality Ontario with recommendations for potential quality standards topics.

• Leverage key learnings from provincial Assess & Restore initiatives to explore interest on the part of provincial stakeholders with expertise in geriatrics to develop an education module for primary care providers.

**APPROACH**

The Assess & Restore/Frail Seniors Advisory and Task Groups worked with stakeholders across the province on the following key activities:

**Developing secondary fall prevention care pathways**

Community-dwelling older adults who present to primary care or the emergency room with a fall are likely to have multiple conditions and complex health needs and can often benefit from rehabilitative services to prevent further functional decline and secondary falls. However, clinicians often have limited awareness of those services and their value or when and how to refer a patient to them. To address this, the RCA developed care pathways that will encourage primary care and EDs to conduct a multi-factorial assessment for risk of functional decline and to connect patients with appropriate rehabilitative care.

As a first step, the RCA conducted a literature review and provincial scan of existing fall prevention pathways and best practices. The task group used this information to develop a clinical care path, which was shared with a broad group of stakeholders. Five feedback meetings were attended by over 20 external stakeholders across five LHINs, representing primary care, emergency medicine, geriatric medicine and inpatient and community rehabilitation. The stakeholders included a wide range of health care professionals with backgrounds in primary care, emergency medicine, occupational therapy, physiotherapy, social work, nutrition and nursing. The RCA Patient/Caregiver Advisory Group was also consulted twice through the review process. Stakeholders provided input on the pathway, including operationalization, communication and implementation strategies, and performance metrics.

Based on this feedback, the task group separated the pathway into two documents to reflect the differences in processes and care provision in primary care and the emergency department. Further revisions included reducing the amount of text to ensure ease of use for clinicians, adding prompts (questions a clinician should ask), increasing the emphasis on an interdisciplinary team approach and adjusting assessment processes to reflect more realistic time frames. The revised pathways were reviewed again by external stakeholders and approved by the Assess & Restore/Frail Senior Advisory Group.

Using the new evidence-based pathways (*Appendix D* and *Appendix E*), clinicians will be able to assess the risk factors that contributed to a fall and stream frail older adults to the appropriate rehabilitative care services: community intervention, outpatient ambulatory/home care, specialized geriatric services or inpatient rehabilitative care.
As the next step, the RCA will pilot the pathways in primary care and EDs in three to four communities across Ontario. The pilot will ensure that all components of the pathways are actionable and determine the steps required to embed the pathways into clinical practice. Modifications to the pathways may also be necessary based on clinician feedback on ease of use.

Facilitating pan-LHIN Assess & Restore knowledge exchange

The RCA hosted annual Assess & Restore (A&R) provincial knowledge exchange forums in 2017 and 2018. Assess & Restore teams from across the province presented on their initiatives, focusing on the following:

- Key impacts of the initiatives, including how they improved health care delivery and/or health outcomes for older adults.
- Challenges faced in engaging partners and creating cross-sectoral care pathways and partnerships.
- Success/engagement strategies that worked well.
- Strategies that did not work well/lessons learned.
- Models of care or engagement strategies that could be replicated in other LHINs.
- Issues related to capacity planning for rehabilitative care for older adults.
- System/resource gaps identified through their initiatives.

At the June 2017 RCA Provincial Forum, five LHINs were selected to share data and learnings related to A&R initiatives that involved primary care as a key partner or community-based initiatives focused on preventing avoidable ED visits and hospitalization.

In 2018, the RCA shifted the format of the annual A&R forum to a three-hour webinar. The November event featured six LHIN initiatives providing services to frail older adults across the continuum of care. Participant evaluations were very positive and recommended that the RCA continue this knowledge exchange format with shorter, more frequent events.

Supporting evaluation of Assess & Restore initiatives

In collaboration with the LHIN leads, the RCA developed a concise set of standardized provincial indicators that align with the MOHLTC-mandated indicators for reporting on A&R-funded initiatives. The technical specifications support standardized measurement and reporting and include: indicator definitions; their relevance to, and alignment with, the objectives of the A&R Guideline; how to measure and calculate results for each indicator; and additional reference information. These standardized indicators allow regions to demonstrate their progress in implementing the A&R Guideline, as well as the collective provincial impact of A&R funding. The indicators also satisfy the MOHLTC reporting requirement.
Analyzing the impact of Assess & Restore initiatives

The RCA conducted an annual analysis of the Assess & Restore initiatives to support knowledge exchange related to A&R approaches and outcomes and to create a shared repository of information about the initiatives. The 2016/17 report and 2017/18 report provide an overview of the initiatives completed in each LHIN. The 2017/18 analysis also uses the shared provincial indicators to establish a baseline that will allow the impact of the initiatives to be measured year over year. Many positive outcomes were noted among the over 33,000 frail older adults served by the initiatives (23,064 served by hospital-based programs and 10,265 in community-based programs). These include improved health outcomes and better patient/client experiences. For example:

- A&R restorative interventions that utilized the Functional Independence Measure (FIM™) demonstrated a 12–20 per cent improvement in function among participating frail older adults.
- Between 70 and 90 per cent of older adults receiving care through A&R initiatives were discharged to their home/original living environment.
- Client and family satisfaction with A&R programs ranged from 85–100 per cent, and consistent improvements were noted on quality-of-life measures.

Advocating for geriatric-focused quality standards

In 2017, the RCA worked with the RGPs of Ontario, to submit two geriatric-focused Quality Standard Feasibility Analyses to Health Quality Ontario with recommendations for the following quality standard topics:

- **Fall prevention in older adults:** Although a number of LHINs have developed fall prevention strategies, the strategies have been implemented in a fragmented and inconsistent manner across the province.

- **Delirium:** Awareness of the issue of delirium has increased as a result of the province’s Senior Friendly Hospital initiative. However, implementation of delirium best practices varies, with the majority of hospitals reporting implementation in less than half of their care units.

Health Quality Ontario chose delirium as a quality standard topic with work expected to begin in 2019.

Exploring an education module for primary care providers

The RCA’s analysis of A&R initiatives found that with appropriate capacity building and education, primary care can play an important role in a proactive approach to providing best practice care for community-dwelling frail older adults with complex health issues. The Project ECHO Care of the Elderly (COE) Team at Baycrest Health Sciences educates primary care providers to help them provide more comprehensive care for this population. A subgroup of the RCA’s task group met with the Project ECHO COE team to discuss potential curriculum related to restorative/rehabilitative care for frail older adults.
KEY LEARNINGS

• **Components of the secondary fall prevention pathways must be actionable.**
  Feedback on the draft pathway provided during the comprehensive stakeholder engagement exercise was overwhelmingly positive. However, there was clear direction that the pathways must be practical and that each component of the pathway must be actionable at a local level. To address this concern, the single pathway was redeveloped into two pathways, specific to either primary care or the emergency department.

• **Success of the pathways will depend on access to the Direct Access Priority Process (DAPP).**
  Direct admission to inpatient rehabilitative care (DAPP) from the community or ED is either non-existent in most regions or very difficult to access. Direct admission is a critical element of the pathways. For that reason, a renewed focus on implementing the DAPP process will be key to the successful broader implementation of the new pathways.

• **Standardized provincial indicators allow LHINs to compare their progress to others and focus their quality improvement efforts.**
  Many A&R initiatives reported positive outcomes; however, not all sites utilized the same indicators or the technical specifications for the shared provincial indicators when measuring outcomes. By adopting these provincial indicators, LHINs will have the ability to better assess their performance against other regions and make necessary improvements.

• **Successful A&R initiatives can point the way to improving care for frail older adults.**
  The RCA’s evaluation and analysis of A&R initiatives over the last five years has identified the following key factors that contribute to enhanced outcomes for frail older adults:
  
  o **A coordinated and integrated approach** to delivering hospital, home, community and primary care services improves outcomes for community-dwelling older adults.
  
  o **Access to comprehensive geriatric assessments and restorative interventions** (e.g., specialized geriatric services) improves outcomes and reduces avoidable admissions.
  
  o **Awareness and competency related to senior-friendly care.**
  
  o **A planned, regional strategy** is required to ensure effective and coordinated care in areas such as early identification, assessment, referral/navigation to bedded rehabilitative care and specialized geriatric services, and transition planning.
IMPACT/VALUE

*Secondary fall prevention*

Falls are a leading cause of injury-related hospitalizations among Ontario seniors. An integrated and coordinated approach is required to address the complex interaction of factors that contribute to these falls and to prevent the functional decline that leads to further falls. The RCA’s secondary fall prevention pathways for primary care and ED provide detailed and practical support to help health service providers adopt a coordinated approach and imbed best practices in care. Implementing the pathways will also help health service providers reduce repeat ED visits for falls, a key indicator of quality measured in the RCA’s annual evaluation of rehabilitative care system performance.

*Assess & Restore initiatives*

A&R initiatives across the province have demonstrated a positive impact on the experience of care and health outcomes of community-dwelling frail seniors. The RCA’s analysis of A&R initiatives has identified key components that contributed to that success. As regions adopt a more population-based approach to health service delivery, these components can provide valuable guidance in planning services for frail older adults. They include the following:

- Enhancing and improving access to restorative care services for older adults.
- Implementing proactive models of risk screening and navigation to keep older adults out of the hospital and providing care in the community, wherever possible.
- Improving outcomes for older adults by implementing best practice care, including comprehensive geriatric assessments and interprofessional geriatric rehabilitative care.
- Developing a regional strategy to ensure initiatives are implementable and sustainable.

**TOOLS/RESOURCES TO SUPPORT IMPLEMENTATION**

- [Assess & Restore 2016-17 Initiatives Overview and Summary Analysis](#)
- [Assess & Restore 2017-18 Initiatives Overview and Summary Analysis](#)
- [Assess & Restore Shared Provincial Indicators](#)
“A standardized approach to older patients after a fall is a valuable addition to Ontario’s Emergency Departments. A pathway that promotes a comprehensive interdisciplinary assessment in the ED and a strategy for linking patients to timely community-based care will make a big difference in both prevention of future falls and high quality rehabilitation for the large number of older Ontarians who suffer a fall.”

Don Melady
Staff Physician, Geriatric Lead
Schwartz-Reisman Emergency Centre, Mount Sinai Hospital

“Falls and the risk of future falls are major concerns for older adults. This guideline provides a succinct framework that can be easily applied in any setting and will help to prevent that downward spiral that falls can precipitate.”

Patricia Ford
Nurse Practitioner
Geriatric Services
St. Joseph’s Healthcare Hamilton
BACKGROUND
The RCA’s Capacity Planning Framework was developed during the RCA’s first mandate to support a standardized approach to capacity planning for rehabilitative services across the province. Implementing a more consistent approach to capacity planning across regions will support equitable access to these services and help regions to address local need now and in the future.

To help LHINs implement the framework, the RCA assisted in defining, gathering and analyzing the required provincial and LHIN-level data. However, as the LHINs began to use the data and apply it to the framework, they requested additional help to support full implementation.

DELIVERABLES
The RCA’s focus for 2017–2019 was to develop a simple, standardized approach to help the LHINs apply the RCA’s Capacity Planning Framework and to develop actionable planning targets for LHINs to use in their regional planning. The deliverables were as follows:

- Develop a simplified approach to help LHINs apply the Capacity Planning Framework, including defining planning scope, data analysis questions and key considerations.
- Provide LHINs with standardized data, methodology and definitions (as needed) to implement this approach.
- Work with a sub group of LHINs to create a process map and help other LHINs apply the simplified approach to their regional capacity planning.

APPROACH
The RCA’s Capacity Planning Task and Advisory Groups led the effort to develop an actionable, simplified approach that would help the LHINs share in collective work and streamline the process of capacity planning for rehabilitative care services.

The groups determined that the approach to capacity planning should:

- Be built around the evidence-informed rehabilitative care needs of patients/clients.
- Seek to optimize the outcomes of patients/clients through emphasis of value-based service provision.
- Account for the preferences and choices of patients/clients where possible and reasonable.
- Provide opportunity for appropriate contextualization within a given region.
- Place emphasis on actionable planning recommendations.
In addition, the task and advisory groups identified that it was important to align the RCA’s approach with the MOHLTC’s capacity planning methodology, which LHINs are currently using for dementia capacity planning. In keeping with that methodology, the RCA adopted the following planning question (based on the RCA’s vision) to guide its work: “How can we optimize patient and system outcomes through the integration of rehabilitative care at all levels of health services policy, planning and delivery?”

**Adopting a health system structural assessment approach**

To assist with its work, the RCA engaged Dr. Matthew Meyer, PhD, an epidemiologist and assistant adjunct professor at the Schulich School of Medicine and Dentistry. Dr. Meyer is the creator of the health system structural assessment (HSSA) approach to capacity planning, which the RCA adopted as the basis for its simplified approach.

The HSSA approach moves beyond the assumption that current service configurations will apply in the future and instead combines best practice guidelines, current evidence and patient feedback to determine future need. As a result, the model not only uses population data to project patient numbers, but also factors in various models of care when considering how many beds and what rehabilitative care services patients will require. For example, it considers what services could be delivered in the community rather than on an inpatient basis. This approach ensures that plans to address future needs are efficient, cost effective and evidence-informed.

Furthermore, because the HSSA approach focuses on patient needs to identify planning targets for future resource requirements, determination of those resources shouldn’t change dramatically across regions. Targets for service provision per patient (and the capacity required to provide these services) should be fairly similar, even when regional context is considered.

As shown in Figure 1 below, the health system structural assessment process is built around a tool called the capacity planning canvas and involves three steps:

1. **Canvas Creation:** A patient population is selected and their health needs determined. The resource requirements and data requirements to meet those needs are then identified to create a capacity planning canvas.

2. **Canvas Application:** The canvas is applied by completing current state and future state calculations to identify gaps in services and resources.

3. **Implementation:** Strategies are identified to address the gaps. The effectiveness of these strategies is evaluated on an ongoing basis, course corrections are made as necessary and the canvas is updated.
Identifying a priority population

To ensure the HSSA approach was applicable and easy to use, it was important to apply it to a test population using provincial and LHIN data. The task and advisory groups used the following selection criteria to identify a priority population:

- strong evidence base for making needs-based decisions
- not duplicative of work already being done in the province
- alignment with MOHLTC priorities
- good quality and available data.

Based on these criteria, the RCA chose to apply the model to the hip fracture population (specifically adults with low-energy trauma hip fracture excluding metastatic disease and motor vehicle collision). Patients with chronic obstructive pulmonary disease (COPD) were identified as an additional priority population.

Creating a capacity planning canvas

The health system structural assessment approach includes the creation and application of a capacity planning canvas; the canvas is both an outcome of the process and an integral tool for guiding the capacity planning work.

Developing a capacity planning canvas is an exercise in vision creation that asks, “What should our rehabilitation system look like?” To answer the question, the process relies on research evidence where
it is available, including best practice recommendations and clinical guidelines, and consensus from subject matter experts, patients, and caregivers where evidence is lacking.

The process is guided by a subject matter expert group that outlines the population under consideration, the needs of that population and the resources required to provide it with best-practice rehabilitative care. The process also actively involves patients from the described population.

When complete, the canvas provides information that can be used to define per-patient service requirements for local rehabilitative care systems. These defined requirements can be combined with local incidence/prevalence information (and adjusted for regional context) to develop actionable planning targets to inform a system-level capacity plan for any region (Figure 2). Once completed, the canvas will not need to be re-done each time it is used, simply updated and adjusted.

*Figure 2: Sample outcome using the hip fracture capacity planning canvas and health system structural assessment approach*

<table>
<thead>
<tr>
<th>For every 100,000 residents of your LHIN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• &lt;&gt; will experience a hip fracture</td>
</tr>
<tr>
<td>• &lt;&gt; will need inpatient care, &lt;&gt; will need outpatient care, &lt;&gt; will need in home care</td>
</tr>
<tr>
<td>• To meet their rehabilitation needs according to best-evidence, you should make available &lt;&gt; hours of PT, &lt;&gt; hours of nursing, &lt;&gt; hours of OT, &lt;&gt; hours of assistant time, &lt;&gt; inpatient rehab bed days, &lt;&gt; outpatient attendances etc.</td>
</tr>
</tbody>
</table>

LHINs where the following factors exist in Higher or Lower levels than the provincial average should plan for INCREASED capacity accordingly:
• Resource-Relevant Factor #1
• Resource-Relevant Factor #2

The Capacity Planning Task Group followed the process described above using the hip fracture patient population. The group worked closely with clinical subject matter experts and drew on best practice recommendations, clinical guidelines and the RCA’s definitions frameworks to identify what rehabilitative care services are needed by patients after a hip fracture and in what settings. A patient/family panel provided valuable insights on these needs and how patients would prefer to have them met. This co-design of the capacity plan by clinical subject matter experts and patients was a key element of success. The RCA also collaborated with Kim Young, a Master’s student in sustainability studies at Trent University, on the use of an online tool for the collection of patient input.

**Developing tools to help implement the HSSA approach**

The RCA developed a number of resources to help LHINs apply the simplified approach to capacity planning for their hip fracture populations. A key tool is an excel worksheet that auto-populates for future state resource requirements based on the needs and resource requirements identified in the
canvas and the current incidence of hip fracture by LHIN. The tool can be modified by LHIN planners to take into account resource relevant factors or LHIN-specific requirements.

The current incidence rate for each LHIN was calculated and provided to the LHINs based on 2017/18 discharges from acute care, where the most responsible diagnosis was hip fracture. (The methodology for obtaining this data was also shared with the LHINs to ensure the capacity planning approach is used consistently across LHINs.)

In addition, the RCA developed a detailed manual on the health system structural assessment approach and the process for applying the capacity planning canvas and tools. The manual provides the necessary background for LHIN planners to contextualize the work and detailed instructions on how to lead the approach for planning of rehabilitative care resources in their regions.

**Testing the HSSA approach and tools in the LHINs**

As a final step, LHIN leads and their teams were invited to test the simplified approach to capacity planning for hip fracture and provide feedback on whether the materials are understandable, applicable and simple to apply. They were also encouraged to include input from clinical and non-clinical stakeholders from their regions. Finally, they were asked to work with their decision support team to compare their current utilization data against the projections generated by the RCA tool so that any questions or concerns could be addressed.

The overall feedback provided from the LHIN testing groups was positive. They indicated that the tools provided exceptional value to regional planners and that teams would benefit from these tools to support planning for all patient populations. The LHIN testing groups also validated the use of the HSSA methodology and the identified settings, services and patient needs. No significant changes were requested to adjust the proposed per-patient service requirements for local rehabilitative care systems.

Each of the LHINs testing the approach worked with their stakeholders to provide detailed feedback on how to improve the tools. In consultation with the LHINs, the RCA prioritized the feedback using three categories: items requiring immediate action, items that can be addressed in training, and lower priority items requiring action in later versions. Their key recommendations were to include more background information and context setting within the worksheets and to provide links to references that explain how the proposed per-patient service requirements were determined. The RCA is addressing these recommendations.

The completed canvas can now be used by regional planners to guide future state resource requirements, while taking into account regional context (such as local incidence/prevalence, population demographics and geographic considerations). Using the simplified approach, planners can also perform gap analyses to assess differences between the region’s current capacity and the proposed future state in the areas of physical space, technologies and human resources.
KEY LEARNINGS

• **Effective capacity planning will require reliable outpatient utilization and outcome data.**
  Efficient use of outpatient models of care will be critical to plan for the future and respond to provincial funding changes associated with bundled funding models. Reliable outpatient utilization and outcome data is needed to support this capacity planning. As a result of the RCA’s work on an outpatient/ambulatory minimum data set, NACRS Clinic Lite is being used to collect outpatient data across the MOHLTC’s hip and knee bundled funding pilot. The continued rollout of NACRS Clinic Lite across all population groups will help regions and HSPs to optimize outpatient rehabilitative care resources into the future. The RCA also continues to explore suitable tools to gather outpatient outcome data.

• **Patients and clinical subject matter experts must be involved in the capacity planning process.**
  Given the limitations of evidence and best practice recommendations, it is critical to have the input of patients and clinical subject matters to determine the needs of patients and the resources required to meet those needs in the future. This also allows for discussion of innovative care models not currently available.

• **Population-specific capacity planning can be extrapolated to other populations.**
  It is difficult to determine the incidence or prevalence of patients with medically complex needs requiring rehabilitation. In the past, age has been used as a proxy; however, individuals with medically complex needs exist across the age span. For example, patients with hip fracture, COPD or congestive heart failure are often frail and medically complex. The RCA’s successful application of the health system structural assessment approach for the hip fracture population has demonstrated that this approach can also be used to plan for other populations with complex health needs.

• **Support from, and collaboration with, capacity planning experts helped the LHINs achieve a greater state of readiness to assess and plan capacity for the hip fracture population.**
  The RCA engaged a capacity planning expert to work with the secretariat and the LHINs to translate the *Capacity Planning Framework* and accompanying data into an actionable tool with planning targets and supporting documents. Drawing on this expertise allowed the RCA and the LHINs to develop a standardized, high quality approach to capacity planning, saving LHINs time. Involving LHIN leads in the testing of the approach was also helpful to ensure the tools met their needs for regional capacity planning and to enable shared learning across LHINs.

IMPACT/VALUE

Capacity planning in health care is critically important to achieve the quadruple aim of improving the health of the population, providing positive patient experiences, ensuring positive health care provider
experiences and reducing the per capita cost of health care. While not enough resources (or poorly coordinated ones) lead to poor health outcomes and negative experiences for patients and staff, too many resources are wasteful and reduce the opportunity to care for other patients. Regardless of the population being planned for or the context in which planning is taking place, patients’ needs should be at the heart of every capacity planning decision.

The RCA’s capacity planning initiative has moved the LHINs closer to achieving these goals. The Capacity Planning Framework provided a consistent provincial approach to defining and planning for rehabilitative care services that could be applied across all regions. The RCA has now advanced that work further by developing a simplified approach that allows LHINs to apply the framework more easily. The RCA has also reduced duplication of effort across the LHINs by completing the complex tasks involved in developing a capacity plan for hip fracture patients.

With the RCA’s support, this improved approach to regional planning for rehabilitative care resources will help regions provide the appropriate services, beds or resources to address the increase in complex patient need expected in the future.

**TOOLS/RESOURCES TO SUPPORT IMPLEMENTATION**

Available to health system planners upon request:

- RCA Hip Fracture Capacity Planning Canvas and Worksheets
- RCA Hip Fracture Capacity Planning Manual
- RCA Hip Fracture Capacity Planning supporting data and technical definitions

“The work that the RCA has done on capacity planning for those with hip fractures is invaluable. The RCA is able to provide us with the leadership to use objective capacity planning frameworks and to bring experts across the LHINs together — both front line and administrative — to come up with a reliable and valid tool to predict the rehabilitation resources that will be required depending on the population size and contextual factors in our respective LHINs. This work at this calibre would not be possible without the RCA’s leadership and collaborative efforts. This is health care dollars working effectively and efficiently at the system planning end!”

Denise Taylor  
North West LHIN Regional Rehabilitative Care Program Manager

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5 Ibid.
BACKGROUND


The RCA’s frameworks support implementation of the QBPs with detailed best practices for rehabilitative care across all care settings: pre-operative (TJR), bedded, ambulatory, in-home and long term care (hip fracture). They have also supported efforts to implement HQO’s Quality Standard for Hip Fracture and the MOHLTC’s hip and knee bundled funding pilot. In addition to providing standardized best practices, the frameworks describe models of care and provide indicators to support performance monitoring of QBP-related outcomes and system performance.

DELIVERABLES

The RCA’s focus for 2017–19 was to support the evaluation, dissemination and implementation of the best practice frameworks. The deliverables were as follows:

- Develop and implement a communication strategy to support dissemination of the RCA rehabilitative care best practices frameworks for patients with hip fractures and TJR.
- Develop tools and resources to support system and/or organizational implementation of the RCA rehabilitative care best practices frameworks for patients with hip fractures and TJR.
- Develop self-assessment tools for organizations across the care continuum to evaluate practices relative to rehabilitative care best practices for patients with hip fractures and TJR.
- Provide sector-specific, LHIN-level gap analyses to inform opportunities for quality improvement in the implementation of rehabilitative care best practices for patients with hip fractures and TJR.
**APPROACH**

The QBP best practices work was led by the Hip Fracture and Total Joint Replacement QBP Task and Advisory Groups, which included representatives from surgical and acute care services, bedded and community rehabilitative care, and regional and provincial home and community care services. The groups focused their work on the following:

**Supporting the QBP Digital Order Sets Program**

In spring 2017, the province’s Digital Order Sets Program expanded to include development of digital order sets for the post-acute rehabilitative phase of care.

The RCA supported the program’s project management office in a comprehensive clinical review of the total joint replacement and hip fracture rehabilitative care order sets. The review included identifying opportunities to incorporate best practices from the RCA’s best practice frameworks into the order sets.

A small working group of the RCA met six times over May and June to review and provide feedback on the first iteration of the order sets. The group provided a number of recommendations related to improving clinical relevance and better aligning the order sets with best practice rehabilitative care. These recommendations informed revisions to the order sets, which were finalized in September 2017.

**Developing tools and resources for implementing the best practice frameworks**

The RCA developed a number of tools and resources to help HSPs implement the best practice frameworks:

- **Quick reference guides**
  The hip fracture and TJR rehabilitative care best practice frameworks are large, comprehensive documents that describe detailed clinical best practices for every setting of rehabilitative care. To help health professionals apply the frameworks, the RCA developed quick reference guides that provide a concise overview of the recommendations for each rehabilitative care setting (bedded, ambulatory, in-home, etc.). Notations indicate where detailed information on a particular recommendation or topic is located in the full framework.

- **Referral decision trees**
  The task group adapted the RCA’s referral decision trees to serve as a decision-making tool to help health professionals determine the optimal location of rehabilitative care for patients following hip fracture and primary hip or knee replacement.

- **Self-assessment tools**
  Sector-specific self-assessment tools were developed to help health service providers identify how well their current practices align with the best practices described in framework. The self-
assessment tools allow organizations to identify practice areas where implementing a change in practice could improve care.

- **Implementation toolkit**
  
  A [slide deck](#) was developed for HSPs to pull all the best practice framework information and tools together for easy reference. It includes an overview of the best practice frameworks, as well as the quick reference guides, referral decision trees, a guide to the self-assessment process and the self-assessment tools.

**Facilitating a provincial self-assessment process**

In February 2018, the RCA initiated a province-wide self-assessment process to allow HSPs to determine how well the care they provide aligns with the best practice frameworks. All HSPs and contracted home and community care providers who provide rehabilitative services were invited to participate.

The RCA provided HSPs with sector-specific self-assessment tools that allowed them to identify how well their current practices align with the best practices described in the frameworks. The tools automatically generated a list of priority areas for improvement. Participating HSPs completed their self-assessments between February and July and submitted them to the RCA. Participation across the province was high: the RCA received a total of 247 self-assessments (116 hip fracture/131 TJR) from 104 organizations across all 14 LHINs (Figures 3 and 4).

*Figure 3: Participation in hip fracture self-assessment by LHIN and sector*
Analyzing provincial and LHIN-level self-assessment data

The RCA analyzed the self-assessment data across organizations to identify quality improvement priorities for each LHIN and to identify system level changes needed at the provincial level to support quality improvement across the province.

For the LHIN-level analysis, the RCA analyzed the data by sector (pre-operative care [TJR], bedded, ambulatory, in-home and LTC [hip fracture]) and identified strengths, weaknesses and areas for improvement across all organizations based on how well they aligned with the best practices. (Specific organizations were not identified.) The RCA also analyzed the quality improvement goals reported by participating organizations and the associated resource needs they identified.

The analysis allowed LHINs to compare their performance against the provincial average and provided insights to help LHINs and HSPs concentrate their quality improvement efforts. The analysis showed that across the province, TJR care is well aligned with best practices, with the exception of pre-operative care. Hip fracture care is not as well aligned and improvements are needed in all sectors.

The provincial analysis was presented at an RCA provincial webinar in October 2018. (This presentation is available for download on the RCA website.) LHIN-level analysis reports were released to the LHINs in November 2018, and the RCA made itself available to present at their regional meetings regarding LHIN-specific findings.
Sharing best practice implementation strategies

The RCA’s analysis identified high-performing organizations across the province that are aligned or mostly aligned with the best practice guidelines. To promote knowledge exchange, the RCA gathered information from these programs on how they successfully implemented the best practices that were challenging for other HSPs across the province. This information was shared in the LHIN-level analysis reports and in an RCA presentation on the innovative strategies of high performing organizations.

KEY LEARNINGS

- **Health service providers across the province have similar challenges in implementing rehabilitative care best practices, regardless of their sector.**

  The RCA’s analysis of the self-assessments revealed common themes across sectors that can provide a focus for future provincial quality improvement initiatives in hip fracture and total joint replacement rehabilitative care. These themes include the following:

  - **Common areas of strength:** Individualized treatment interventions; patient and caregiver engagement; dedicated inter-professional teams in pre-op, bedded, in-home and long term care sectors; and establishing goal-directed plans of care.

  - **Common opportunities for improvement:** Patient and family education materials; communication across the continuum of care; use of validated outcome measures and risk assessment tools; addressing dementia, delirium and depression among hip fracture patients; and addressing pre-operative supports for TJR patients.

- **Knowledge exchange is key to ensuring that all programs benefit from innovative approaches. There is no need to reinvent the wheel.**

  As HSPs move to implement rehabilitative best practices, they can benefit from opportunities to learn from innovative quality improvement strategies used by high performing organizations across the province. There is also an opportunity to leverage existing best practice resources provided by organizations such as Osteoporosis Canada and the RGPs of Ontario.

IMPACT/VALUE

The RCA’s best practice frameworks for hip fracture and TJR rehabilitative care provide a detailed guide to the processes, resources and structures required to provide care that supports optimal patient outcomes and patient flow. They also provide HSPs with evidence-based, provincially endorsed recommendations to support standardized implementation of hip fracture and TJR QBPs across rehabilitative care settings. The RCA’s quick reference guides and implementation tool kit provide support and guidance to help organizations implement the frameworks.

HSPs across the province have demonstrated a strong commitment to aligning the care they provide to patients with hip fracture and TJR with standardized, rehabilitative best practices. This engagement was reflected in high participation levels in the provincial self-assessment process and allowed the RCA to
conduct a robust analysis of how well hip fracture and TJR rehabilitative care across the province aligns with best practices. The resulting provincial and regional analyses provide the basis for data-driven quality improvement planning. The analyses will allow HSPs to focus their improvement efforts and enhance the quality and efficiency of the rehabilitative care they provide.

**TOOLS/RESOURCES TO SUPPORT IMPLEMENTATION**

- **Hip Fracture**
  - [Rehabilitative Care Best Practices Framework for Patients with Hip Fractures](#)
  - [Quick Reference Guides: Bedded, Ambulatory, In-home, Long-term care](#)

- **Primary Hip and Knee Replacements**
  - [Rehabilitative Care Best Practices Framework for Patients with Primary Hip and Knee Replacements](#)
  - [Quick Reference Guides: Pre-operative, Bedded, Ambulatory, In-home](#)

- **Self-Assessment Tools**
  - [Hip Fractures: Bedded, Ambulatory, In-home, Long-term care](#)
  - [Primary Hip and Knee Replacements: Pre-operative, Bedded, Ambulatory, In-home](#)

- Toolkit for Implementing Best Practice Frameworks
- Hip Fracture and TJR Self-Assessment High Performers: Best Practice Implementation Strategies

“This initiative has been key in setting the stage for standardization of high quality care based on best practices throughout the province. It empowered regions to have input into the best practices framework, understand best practices and engage in quality improvement assessments that resulted in action plans that will continue to advance patient care for optimal outcomes.”

Debra Carson
Vice President, Patient Care Services
Trillium Health Partners
System Evaluation
Improving quality through standardized evaluation

BACKGROUND

In the RCA’s first mandate, the RCA’s Rehabilitative Care System Evaluation Framework was developed to support a standardized approach to evaluating system performance across the rehabilitative care continuum. This standardized approach is intended to support evidence-based practice and system-wide improvement, including the prioritization of regional and provincial quality improvement opportunities. Using that framework, the RCA published its first Rehabilitative Care System Performance Report in March 2017.

DELIVERABLES

From 2017–2019, the RCA’s focus was to continue the standardized evaluation of rehabilitative care system performance at the regional and provincial levels using a set of key indicators and to begin taking steps to use this data for quality improvement. The deliverables were as follows:

- Develop the next iteration of the provincial rehabilitative care system scorecard and a process for ongoing annual reporting via a performance report.
- Identify opportunities for the LHINs to help them improve quality with respect to their regional performance against provincial benchmarks.

APPROACH

The work of the System Evaluation Task and Advisory Groups focused on the following:

Developing the next iteration of the provincial rehabilitative care system scorecard

In November 2018, the RCA released its third annual report on the quality of rehabilitative care provided across the province. The 2017/18 Rehabilitative Care System Performance Report reported on eleven indicators within the quality domains of access, safety, effectiveness and integration. Performance was reported against provincial benchmarks for three of the indicators: wait times for inpatient rehabilitative care, wait times for in-home rehabilitative care and repeat emergency department visits due to falls.

The 2017/18 report was released to RCA stakeholders, including RCA committees, LHINs, the MOHLTC and other provincial organizations. It included an extensive analysis of the data and used an interactive scorecard format to allow easy comparison of data across LHINs, supported by analysis, data tables and technical definitions for each of the indicators. The RCA had previously developed and tested the scorecard format with LHINs and provincial stakeholders as part of its ongoing process of improving the report format.
Building awareness of the reporting process

The RCA developed a communication plan to increase awareness among stakeholders of the overall objective of province-wide reporting, the benchmarks, their origins and the process that led to them. Additional work was undertaken with some stakeholders to build comfort with/support for reporting data on specific indicators at a LHIN level. The secretariat also delivered presentations to seven LHINs that requested support to provide an overview of the data to regional rehab committees.

The secretariat also engaged with other provincial groups such as Health Shared Services Ontario – Home and Community and organizations that publish performance data (OHA, HQO) to elevate the awareness of key rehabilitative care system performance indicators and benchmarks. A poster presented at HQO’s Health Quality Transformation conference in 2017 provided an additional opportunity to reach out beyond RCA stakeholders. The poster, “Setting Benchmarks for Rehabilitative Care: Determining and Reporting Benchmarks,” won a Poster of Distinction award.

Developing a review process

Because RCA reports are widely circulated among provincial stakeholders, it was important to develop a process to share the data and report with LHINs in advance of publication. This pre-publication review ensures data accuracy and allows the LHINs to begin planning quality improvement strategies. A review process was established with the 2016/17 report and continued with the 2017/18 report. The data reporting and scorecard publication process was also refined and streamlined. As a result, the 2017/18 performance report was completed in three months versus the eight months required for previous reports. This allowed the RCA to shift publication of the annual report to Q3 to maximize its usefulness.

*Figure 5: Annual reporting process*
Identifying priorities for future indicators and benchmarks

The task and advisory groups also began the process of identifying future priorities for indicators and benchmarks. The groups recommended that the RCA undertake an ongoing review of the benchmarks and indicators in the system evaluation framework on a three-year cycle to determine which should be developed, included or retired from the scorecard and report.

Implementation of the evaluation framework and annual system performance reports is still relatively new. As a result, the task and advisory groups proposed postponing any process to expand the number of benchmarks until reporting has been fully underway for several years to allow organizations to focus on improving their performance against the current benchmarks. The groups suggested the RCA’s more immediate focus be to support HSPs and LHINs in achieving the three existing benchmarks and to create processes to support the RCA’s organization-level reporting.

However, the groups identified the following indicators as a priority for inclusion in the performance report when an expansion is considered:

<table>
<thead>
<tr>
<th>INDICATOR NUMBER</th>
<th>REHABILITATIVE CARE SYSTEM INDICATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2</td>
<td>Time from referral to first outpatient rehabilitation therapy appointment (by referral source, i.e., acute, bedded levels of rehabilitative care or community)</td>
</tr>
<tr>
<td>B9</td>
<td>Proportion of programs/services that align with definitions framework</td>
</tr>
<tr>
<td>D1</td>
<td>Rehabilitative care system cross-continuum patient experience</td>
</tr>
<tr>
<td>E1</td>
<td>To support measurement of equity and to illustrate potential differences across population groups, measures from other dimensions may be considered though an equity lens/filter, e.g., age, sex, education, language, regional variations, income, etc.</td>
</tr>
<tr>
<td>H2</td>
<td>Evidence of rehabilitative care system capacity planning every five years</td>
</tr>
<tr>
<td>B1</td>
<td>Readmissions within 30 days for selected case mix groups after receipt of bedded, in-home or outpatient/ambulatory rehabilitative care service</td>
</tr>
</tbody>
</table>

Using evaluation data for quality improvement

The task group also addressed the strategic issue of how to use the data being reported for quality improvement. The group drafted their own quality improvement approach using root cause analysis to better understand the issues affecting LHIN performance against the three priority
indicators/benchmarks, how the RCA can support their quality improvement efforts, and what policy or resource issues LHINs will need to address. The process involved several steps:

- Identifying subject matter expert groups, one for each of the priority indicators.
- Conducting a condensed root cause analysis in two-hour meetings with each subject matter expert group through fall/winter 2018.
- Inviting the group to prioritize the list of change ideas identified in the meetings by voting in a Delphi process supported by an effort/value matrix.

This process complements the secretariat’s ongoing meetings with the LHINs to help them interpret their data and monitor their performance. LHINs received the completed root cause analysis for the RCA’s three priority indicators and the list of prioritized change ideas to consider in their quality improvement work. The package also included the root cause analysis template and instructions so that LHINs could use the process at regional LHIN tables to reflect on LHIN-specific opportunities for quality improvement.

**KEY LEARNINGS**

- **Having timely access to data is necessary for quality improvement work at the regional level.**
  
  LHIN leads and providers across the province continue to emphasize the importance of timely access to data and analysis to support their quality improvement efforts. The RCA has refined its data publication process to reduce the time required to share indicator data and analysis. Publishing the rehabilitative care system evaluation performance reports no later than Q3 of the following fiscal year will allow providers to act on quality data while the information is still relevant.

- **Ongoing review of the indicators is critical to ensure they meet performance needs/interests.**
  
  Trends in health information management, data reporting and indicators suggest that the strategic application and use of data and indicators is more important than the volume of data. LHINs and other provincial stakeholders have found the RCA rehabilitative care system evaluation performance report is a valuable support to their quality improvement efforts and suggest additional indicators should be added only when quality improvement opportunities related to the first three indicators have been addressed. This will allow organizations to focus on addressing the current indicators and become further accustomed to the RCA reporting process. To ensure the strategic alignment of data with system needs continues, the RCA will conduct an ongoing review of the benchmarks and indicators in the system evaluation framework on a three-year cycle.
• Reporting at the organizational level will provide additional opportunities for quality improvement.

Stakeholders have expressed a strong interest in obtaining data at an organizational level to allow them to gain a deeper understanding of each organization’s contribution to regional performance and identify sub-regional opportunities for improvement.

• An established process for review of performance data is essential to confirm and improve data quality.

The quality and value of the rehabilitative care system evaluation report depends on high quality, timely and accurate data. For this reason, the RCA has established a process for data quality review with the LHINs that will ensure the reports continue to be a reliable source of data for all system stakeholders.

• A root cause analysis identifies opportunities to improve performance.

The RCA conducted a quality improvement exercise to identify root causes and potential change ideas to help LHINs improve their performance against the three priority indicators in the system evaluation report. Subject matter experts evaluated the many proposed change ideas against effort and impact and have prioritized the following as areas of focus:

  o To reduce inpatient rehabilitative care wait times: Applying RCA definitions framework in order to improve consistency in eligibility criteria, ensure appropriate referrals and align the Wait Times Information System with these definitions; addressing the long intake assessment process for convalescent care; and at the regional-level, putting in place processes to ensure early, continuous, transparent communication with patients and caregivers regarding future and alternate options.

  o To reduce in-home rehabilitative care wait times: Updating and consistently applying a standardized approach to triaging patients for in-home rehabilitative care services; developing regional or local processes and timelines for transfer of referral information to home and community care; and ensuring a referral process that is transparent to all involved.

  o Reducing repeat ED visits for falls: Implementing post-fall pathways that identify clinical root causes of falls; embedding best practices into ED discharges and digital order sets; and supporting implementation with appropriate resources and community collaboration.

**IMPACT/VALUE**

Through its *Rehabilitative Care System Evaluation Framework* and annual rehabilitative care system performance reports, the RCA has laid the foundation to support standardized regional and system-wide performance reporting. This access to timely, high quality data will allow for comparison of local performance on key rehabilitative care system indicators against that of other regions and against provincial benchmarks.
More recently, the RCA has focused on how to use the reporting process and three years of data from the priority indicators to support quality improvement regionally. It has done this by sharing quality improvement learnings with the LHINs — both key change ideas for improving performance and the process for undertaking a root cause analysis. These continued efforts will help to optimize rehabilitative care performance both regionally and provincially as an enabler of quality health care overall.

**TOOLS/RESOURCES TO SUPPORT IMPLEMENTATION**

- *2017/18 Rehabilitative Care System Evaluation Performance Report* (Available to health care professionals and LHIN staff upon request.)

- *FAQ – Rehabilitative Care System Evaluation Performance Report*

> “The 2013 Auditor General’s report called for the development of standardized performance measures that provide hospitals with “useful and comparative information” to allow them to benchmark their performance against other hospitals and identify areas that need improvement. The RCA has been instrumental in addressing this recommendation through meaningful tools and data systems that are being used in many initiatives, including bundled care and health provider quality improvement plans.”

Imtiaz Daniel, Director, Financial Analytics and System Performance
Ontario Hospital Association
Chair, RCA System Evaluation Task Group
Definitions
Implementing provincial standards for rehabilitative care programs

BACKGROUND
The RCA has established provincial standards for levels of rehabilitative care through its Definitions Framework for Bedded Levels of Rehabilitative Care and Definitions Framework for Community-Based Levels of Rehabilitative Care. The frameworks define the focus and clinical components of rehabilitative care programs to provide consistency across the province and clarity for patients, families and referring professionals. A shared understanding of rehabilitative care also supports capacity planning at the local and system level.

DELIVERABLES
The focus for 2017–2019 was to support LHINs and HSPs in the implementation of the frameworks in their regions and to address system-wide barriers. The deliverables were as follows:

- Work to address common barriers to full implementation and sustainability of the definitions frameworks:
  - Identify and implement required changes to the Provincial Referral Standards (PRS) to support alignment with the Definitions Framework for Bedded Levels of Rehabilitative Care and disseminate the revised PRS through LHIN Leads across the province.
  - Work with Access to Care (ATC) to align provincial and LHIN-level reporting of alternate level of care data with the levels of care in the Definitions Framework for Bedded Levels of Rehabilitative Care.
  - Work with the MOHLTC/OHA Inpatient Rehabilitation Care Technical Task Group to evaluate the current inpatient rehab grouper and make recommendations for refinements to the re-designated case mix methodology and weights to be used for funding.
- Identify/develop standardized information and a naming convention for rehabilitative care and address challenges to implementing the definitions frameworks.
- Develop and implement a centralized rehabilitative care portal through thehealthline.ca to provide rehabilitative care information for the public.
- Develop and implement a framework to evaluate uptake of the definitions frameworks for levels of rehabilitative care across the province.
APPRAOH

Efforts to support further implementation of the definitions frameworks were led by the Definitions Advisory Group and the Health Service Providers Definitions Implementation Group (HSP DIG). HSP DIG provided important input on operationalizing the frameworks, meeting every six to eight weeks to identify implementation issues and share challenges and successful strategies. The groups focused their work on the following:

Reducing structural barriers to implementing the frameworks

The RCA recognized that a key enabler of full implementation and sustainability of the frameworks is the alignment of provincial reporting and referral tools.

Aligning ALC data reporting

In April 2017, the RCA began discussions with Access to Care (ATC) on the value of aligning ATC’s Wait Times Information System-Alternate Level of Care (WTIS-ALC) reporting system with the new bedded levels of rehabilitative care. ATC was fully supportive. The RCA proposed aligning the bedded levels with the discharge destination options and Continuing Care Reporting System (CCRS) and National Rehabilitation Reporting System (NRS) reporting bed types in the WTIS-ALC reporting system. Between fall 2017 and spring 2018, a group of subject matter experts involved with ALC reporting in five of the LHINs met to review the proposed model and provide guidance on additional considerations for implementation. The RCA also kept a larger province-wide ATC group informed on the proposed change. The model was finalized as a result of these discussions. However, ATC has reported that it cannot implement this reporting change until Q1 2020/21. In the interim, the RCA continues to meet with ATC and will work with them on strategies to support this change in reporting.

Aligning provincial referral standards

The Provincial Referral Standards were released in 2014 by the Provincial Standards Sustainability Office (now closed) to provide a standardized data set for referrals from acute care to inpatient rehabilitation and complex continuing care, as well as to other discharge destinations.

To ensure that the language within the PRS for referrals to inpatient rehabilitation aligns with the bedded definitions framework, the RCA worked with its stakeholders in January 2018 to update the Provincial Referral Standards and associated reference guide. These two resources are now hosted on the RCA website.

Refining the inpatient rehabilitation grouper

The RCA’s Executive Director continued to participate in discussions of the MOHLTC/OHA Inpatient Rehabilitation Care Technical Task Group to evaluate the current inpatient rehabilitation grouper and make recommendations for refinements to the re-designed case mix methodology and weights to be used for funding. A report is expected in early 2019/20.
Developing standardized information for rehabilitative care

The RCA helped organizations to implement the frameworks by developing standardized resources/tools that can be customized to reflect regional information on rehabilitative care. These resources included the following:

- **Community-based referral options tool**
  LHINs and HSPs can use this tool to provide information on community-based rehabilitative care delivered by regulated health professionals within their regions. The standardized resource assists referrers when looking for options for their patients/clients. A guideline was also developed to support consistent descriptions across LHINs. (The RCA released a similar tool for bedded referral options in 2016.)

- **Patient/caregiver information letters on the levels of rehabilitative care**
  These letters provide brief, standardized information describing the levels of care in the patient’s journey. While they use consistent language to describe rehabilitative care options, the letters can also be customized to reflect regional programs. The three letters for rehabilitation, activation/restoration and short-term complex management levels of care have also been translated into French.

- **Standardized naming convention for rehabilitative care**
  The RCA Standardized Naming Convention (Figure 6) minimizes variation in rehabilitative care descriptors and helps to reinforce a shared understanding of rehabilitative care. The naming convention is applied at the front of existing program names for reporting and navigation purposes (e.g., WTIS-ALC reporting; regional navigation tools such as Rehab Finder; Resource Matching & Referral systems; and thehealthline.ca). This allows organizations to continue to use existing program names with patients/families if they wish. For example, an organization’s Restorative Care Program would be classified as Activation/Restoration: Restorative Care Program for reporting purposes. (See the convention document for further details.)
Addressing implementation challenges

Meetings of the advisory and HSP DIG groups provided a regular forum for LHIN Leads and HSPs to share operational questions and learnings and to identify system-wide challenges. Committee members benefited greatly from hearing from other regions where implementation was more advanced. The 71 members of the two groups included LHIN leads and HSPs from all LHINs, providing a broad perspective and a wide range of experiences with implementation.

The RCA’s Executive Director and Definitions Project Manager also met directly with regional rehabilitation committees to support LHINs and HSPs in aligning rehab/CCC programs with the bedded definitions. This included an in-person presentation and discussion with the North East LHIN Rehabilitative Care Committee (February 2018) and a Toronto meeting with the North East Geriatrics regional lead and administrative staff from the Sault Area Hospital (March 2018).

In addition, the RCA held two well-attended province-wide informational webinars on implementing the definitions frameworks in April and May 2018. The presentation and audio recordings of both webinars were posted on the RCA website.

Developing a provincial rehabilitative care portal

To help the public and providers easily access information on rehabilitative care, the RCA developed a centralized rehabilitative care portal (www.rehabcareontario.ca). A single access point for information, the new portal supports communication about rehabilitative care and improves navigation to rehabilitative care services for clients, families and providers.

The portal was developed in collaboration with thehealthline.ca (THL), an existing provincial online health information website/navigation tool that provides a wide range of health information. However,
information on rehabilitation was difficult to find on the website. The RCA partnered with THL to integrate the existing rehabilitative care information into a single access point and align the information with the RCA’s definitions frameworks. Regional THL site managers will maintain and update organization-specific information.

The RCA solicited input from multiple stakeholders during the development process to ensure the project’s success, including the RCA LHIN leads, regional THL site managers and data administrators, the RCA Patient/Caregiver Advisory Group, the Definitions Advisory Group and HSP DIG. The RCA also worked with Health Shared Services Ontario to incorporate RCA’s terminology on thehealthine.ca.

Evaluating uptake of the frameworks across the province

The RCA conducted an evaluation to determine the extent to which LHINs and HSPs have implemented the definitions frameworks, whether this has helped with their rehabilitative care planning, implementation challenges they faced and the strategies they used to address them.

The RCA worked with a consultant to develop an evaluation framework with input from individual stakeholders, the Definitions Advisory Group and HSP DIG. The evaluation was conducted from April to June 2018, with separate surveys for bedded and community-based rehabilitative care programs sent to all LHIN leads and over 125 health service providers. The RCA received a total of 78 completed surveys, representing 12 of 14 LHIN leads and 66 HSPs from across regions. The results indicate:

- The definitions frameworks have been helpful for both LHIN leads and HSPs in planning for rehabilitative care.
- The frameworks have been widely implemented. More than 70 per cent of respondents reported partial to full implementation of both the bedded and community-based frameworks with respect to consistency between the RCA eligibility criteria and program admission criteria, use of the RCA naming convention (bedded programs) and alignment with recommended health human resources.

Each LHIN lead received a summary and detailed survey findings reflecting the responses from all LHIN leads, as well as HSPs from their region. They were asked to share the findings with their HSPs as appropriate.

KEY LEARNINGS

- There’s no such thing as too much information sharing.
  Ongoing information sharing (through various means) and discussion with stakeholders is a key enabler for implementation. Providing multiple opportunities for stakeholders to come together serves to
  - Promote a thorough understanding of the initiative and the implications of implementation at an operational level.
- Ensure that awareness remains high even when there are staffing changes.
- Clarify inaccurate assumptions and identify and problem-solve when challenges arise.
- Share real-life examples of how the work has been done at an organizational and regional level.
- Support organizations as they reach a state of readiness to implement change.

**Removal of structural barriers is easier said than done.**

The RCA was proactive in its engagement with ATC regarding the alignment of ATC WTIS-ALC reporting with the definitions frameworks. However, the process for confirming the proposed model for re-alignment was lengthy and not under the RCA’s control. In addition, implementing the revisions to the reporting system is dependent on ATC’s internal priorities and timelines.

**Evaluation involves trade-offs between obtaining comprehensive information and minimizing the burden for survey respondents.**

The evaluation framework underwent several iterations. Initial drafts focused on obtaining as much feedback as possible on the status of implementation using multiple indicators. However, it became clear that the surveys had to be streamlined to encourage participation, particularly as respondents were being asked to complete surveys for both bedded and community-based rehabilitative care.

**Further support is needed to ensure the frameworks are fully implemented across the province.**

The scope of the definitions initiative has been far-reaching and substantial progress has been made. However, the evaluation identified that further support is needed in the following areas:

- **Re-categorization and application of the RCA standardized naming convention:** Further education is needed to increase HSP understanding of re-categorization of rehabilitative care programs and how it can be applied so that reporting in navigation tools, websites and other resources is aligned with the levels of care. There is also a need for more organizational buy-in and consistency in the uptake of the definitions framework and its terminology.

- **Ongoing education:** Ongoing education at the front line level is needed to increase awareness and understanding of the definitions frameworks and terminology among staff and physicians. In particular, education is needed to support consistency in the interpretation and application of the definition of restorative potential and eligibility criteria for that level of care.

- **Health human resources:** Guidelines for therapist/patient ratios are needed to help address challenges in implementing the health human resource recommendations in the bedded frameworks.
IMPACT/VALUE

The scope of the RCA's definitions initiative has been far-reaching, and the evaluation results demonstrate that there has been significant progress in establishing a common understanding of rehabilitative care across the province. The RCA’s efforts in the following areas have contributed to that progress:

- **ALC reporting re-alignment**: The alignment of the WTIS-ALC reporting system with the bedded levels of rehabilitative care will remove an important structural barrier to achieving implementation of the frameworks across the province. This re-alignment promotes consistency in the understanding of what is being reported and greater consistency in the reporting of ALC across the province.

- **Updating provincial referral standards**: Alignment of the terminology in the *Provincial Referral Standards* with the definitions frameworks promotes consistency in the language used to describe rehabilitative care and serves to strengthen a common understanding across the province of the levels of rehabilitative care.

- **Use of standardized resources/tools and naming convention**: Providing standardized resources/tools and a naming convention for rehabilitative care promotes a common understanding and language for rehabilitative care across the province. This has laid the foundation to support consistency in regional and system-wide planning and reporting of rehabilitative care, allowing comparison of programs within regions and across regions. Standardizing program naming also supports better communication with patients/caregivers.

- **Rehabilitative care information for the public**: The RCA’s new provincial portal (www.rehabcareontario.ca) provides a centralized access point for rehabilitative care information for the public and providers. The portal allows clients, families and providers to find and navigate publicly-funded rehabilitative care services more easily, addressing the Ontario Auditor General recommendation to “provide the public with detailed information on programs available, eligibility and how to apply, such as through a public website.” (Auditor General Report, 2013). While the portal provides information on rehabilitative care services in a more standardized way, information is customized for each region.

- **Implementation evaluation**: The RCA’s evaluation provided the RCA and the LHINs with important information on how far implementation has progressed, areas where continued RCA guidance and support will be needed to ensure further spread and integration of the frameworks, and specific areas that will require targeted efforts.

The combined impact of these efforts, together with further support and guidance from the RCA, will support the continued spread, integration and sustainability of the definitions frameworks. The result will be a clearer understanding of rehabilitative care and a more consistent approach to its planning and provision across the province.
TOOLS/RESOURCES TO SUPPORT IMPLEMENTATION

- Patient/Caregiver Information Letters on Bedded Levels of Rehabilitative Care: Rehabilitation; Activation/Restoration; Short Term Complex Medical Management (French translations available upon request)

- Referral Options Resource for Community-Based Levels of Rehabilitative Care

- Referral Options Resource for Community-Based Levels of Rehabilitative Care: Primary Care

- Guideline for Formatting Program/Service Information in the Referral Options Resources for Community-Based and Bedded Levels of Rehabilitative Care

- Standardized Naming Convention

“The definitions framework has provided a common language among health service providers, enabling us to identify the right level of care for our patients at the right stage in their rehabilitation journey. As we collaborate to achieve alignment with the levels of care in the framework, we are creating a health care system that is focused on meeting our patients’ rehabilitation needs at every step in their journey so they can regain and maintain their independence.”

Kari Gervais
Vice President, Clinical Services
St. Joseph’s Health Centre of Sudbury
Outpatient Reporting

Tracking performance outcomes for outpatient rehabilitation

BACKGROUND

Standardized data collection for outpatient/ambulatory rehabilitative care has been identified as a priority to support funding and planning decisions and ensure patient access to services.6, 7 As LHINs and health service providers implement best practices and quality-based procedures, the focus on outpatient rehabilitative care continues to grow.

In its first mandate, the RCA developed a standardized **Outpatient/Ambulatory Rehabilitative Care Minimum Data Set** to support standardized data collection, the development of comparable performance metrics and capacity planning at organizational, regional and provincial levels. The RCA then conducted phase one of a provincial proof of concept in 2016/17 to pilot the minimum data set and the use of three data collection and reporting tools: National Ambulatory Care Reporting System (NACRS) Clinic Lite (access and service utilization measure), the Community Rehab Assessment (CRA) (functional outcome measure) and the WatLX™ (patient experience measure). This marked the first time that comparable, standardized data were collected and reported across outpatient/ambulatory rehabilitative care programs in Ontario.

DELRIVERABLES

For 2017–19, the RCA focused on developing strategies and recommendations to expand the rollout of the three outpatient data collection tools. The deliverables were as follows:

- Produce a detailed report of the findings from the first provincial proof of concept in the collection and reporting of outpatient/ambulatory rehabilitative care data.
- Develop a strategy for broader roll out of the outpatient/ambulatory minimum data set that reflects the recommendations from the provincial proof of concept and includes refined reporting parameters.
- Develop a strategy to enable all ambulatory/outpatient rehab programs to report utilization data to the Canadian Institute for Health Information (CIHI) through NACRS Clinic Lite.
- Work with InterRAI researchers and provincial stakeholders to review the results of the provincial proof of concept, make modifications to streamline the Community Rehab Assessment tool and pilot the next version with sites on a voluntary basis.

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• Work with the developers of the WatLX™ tool to explore integration of this patient experience tool across outpatient/ambulatory rehab programs as feasible.

APPROACH
The RCA’s Outpatient/Ambulatory Task and Advisory Groups worked with a variety of stakeholders to implement the recommendations from the 2016/17 proof of concept. Their approach was as follows:

Reporting the findings from the provincial proof of concept
As a first step, the RCA released the full results from the proof of concept, *Rehabilitative Care Alliance Outpatient Ambulatory Provincial Proof of Concept - Phase I Report*. The report includes a provincial analysis of utilization of outpatient rehabilitative care, results on patient experience, an analysis of functional improvement over an outpatient episode of care and recommendations for next steps.

Supporting provincial rollout of outpatient/ambulatory data tools

*NACRS Clinic Lite – Access and Service Utilization*
Sites that piloted the use of NACRS Clinic Lite in 2016 to gather outpatient access and utilization data recommended that the tool be modified to significantly reduce data entry demands on staff. To address this, the RCA worked with CIHI to create a simpler one-record summary that staff complete at discharge. The updated tool was made available to all organizations in early 2018 to document outpatient utilization for all patient populations.

In April 2018, the MOHLTC began a provincial pilot of bundled funding for primary unilateral total hip and knee replacements and required all participating outpatient rehabilitative care providers to use NACRS Clinic Lite to report outpatient/ambulatory rehabilitation data. The RCA worked with CIHI, HQO and the MOHLTC throughout 2018/19 to support outpatient providers and bundle holder sites. In the early stages of the pilot, the RCA provided participating sites with a tool for tracking data to use in the interim period before they gained access to NACRS Clinic Lite. The RCA then worked with the MOHLTC, HQO, and CIHI to deliver ten educational sessions on the use of NACRS Clinic Lite to capture outpatient rehab access and service utilization data and provided sites with significant one-on-one support. The RCA and CIHI also provided technical onboarding support to over 24 outpatient sites between June and October 2018.

The MOHLTC is expected to release data from the bundled funding pilot in the first or second quarter of 2019/20. The RCA will use the outpatient data to conduct its own evaluation of the outpatient data reporting process (e.g., is the data set sufficient? easy to use?) and to analyze the utilization of outpatient rehabilitation (e.g., did it align with expectations and funding?).

*WatLX™ – Patient Experience*
In 2016, the RCA successfully piloted the use of the WatLX™ *Outpatient Rehabilitative Care Experience Survey* with 22 hospital and community-based programs, who tested the WatLX™ survey with over 1000
patients. (The tool was developed by researchers at the University of Waterloo and Wilfrid Laurier University in collaboration with the RCA.)

Feedback from patients and providers was positive, and beginning in July 2018, the tool (in both French and English) was made available to hospitals to collect data on patient experience during outpatient care through the Ontario Hospital Association (OHA) and NRC Health.

NRC Health distributes the outpatient survey (by email, phone, mail or handout), collects and manages the data centrally and produces reports. Any hospital-based outpatient rehabilitation clinic can access the tool through their Patient Reported Performance Measurement (PPRM) contract with the OHA and NRC Health. Non-OHA members, or those who wish to administer the tool themselves, can access the WatLX™ by contacting the developers directly.

**Community Rehab Assessment – Functional Outcome**

Based on feedback from the RCA’s successful pilot of the community rehab assessment tool in 2016, the RCA conducted a phase II pilot of the revised tool in 2018. The tool, which assesses patients on a wide variety of functional domains, was shortened and streamlined to reduce the data entry time for clinicians and to better integrate the tool with current processes for admission and discharge assessments. The phase II pilot had the following objectives:

- Demonstrate how the CRA can be used to measure functional change across patient populations.
- Demonstrate how the CRA can be used to describe outpatient/ambulatory rehabilitation populations.
- Refine the CRA by engaging in a qualitative appraisal process with users (clinicians, administrators).
- Identify practices that support clinic capacity planning and administration.

For this nine-month pilot, the secretariat required participating sites to capture data (completed admission and discharge assessments) for a minimum of 15 patients. This minimum provided sufficient data for the RCA to assess how easily sites integrated the CRA into their standard processes — qualitative data that will be used to guide future refinements of the tool. The secretariat also asked sites to focus on enrolling patients receiving outpatient rehabilitation for specific conditions (acquired brain injury, TJR, neurological issues, stroke, or an orthopedic need other than TJR or hip fracture) so the resulting data set would have sufficient statistical power to allow comparison across rehabilitation population groups.

A total of 25 sites across the province participated. Each site received an analysis of its own data, and results were also analyzed across all sites where the number of completed assessments for a patient group was 50 or more. Sufficient numbers were available to complete a provincial analysis for knee replacement, stroke and hip replacement patient populations. (Fewer than 50 assessments were submitted for each of the other patient populations.)
Feedback from participating sites was collected throughout the project during task group meetings and through a set of evaluative questions distributed one month after the project start date and again at the completion of the project. This feedback is reflected in the key learnings included below and has been used to determine next steps.

**Building on Ontario’s success**

The RCA is a national leader in implementing standardized data collection for outpatient/ambulatory rehabilitative care. Ontario is the first province to use NACRS Clinic Lite to report access and service utilization data for outpatient rehabilitation, and the RCA has been contacted by health providers across Canada that are interested in Ontario’s approaches to collecting utilization, patient outcome and patient experience data. The secretariat also met with Alberta Health Services, Island Health (Vancouver Island) and Vancouver Coastal Health to share learnings on implementing outpatient rehabilitation data collection, particularly in the area of functional outcome. The secretariat has also been invited to participate on, and present to, the CIHI Rehabilitation National Advisory Committee.

**KEY LEARNINGS**

- **Successful early rollout of the NACRS Clinic Lite tool has laid the groundwork for expansion to other populations.**
  
  Sites participating in the MOHLTC’s hip and knee bundled funding pilot have successfully implemented NACRS Clinic Lite to gather utilization and wait time data for outpatient rehabilitative care. The value of the data has highlighted the need for similar data for other rehab populations, and with the foundational work completed (onboarding, training, process development, data quality steps, etc.), it would be easy to expand data collection to additional populations. Outpatient data will play a crucial role in planning for transitions from hospital to home and in the renewed focus on community options for health care.

- **WatLX™ is now available for use, but has not yet been widely adopted in hospital-based outpatient/ambulatory care.**
  
  The WatLX™ tool for patient experience data was made available to hospital-based clinics through NRC Health and the PRPM contract with the OHA in September 2018. No sites have taken advantage of this opportunity to date; however, some have expressed interest in beginning the process in the new fiscal year. Further work is also needed to explore barriers to implementing the tool and motivations for collecting patient experience data in the outpatient rehab setting.

- **Consistent reporting of patient outcomes is needed to complement patient experience and utilization data.**
  
  As the MOHLTC continues to move forward with bundled funding models, there will be greater pressure to demonstrate the role and value of outpatient rehab in the care pathway and in a best practice service delivery model. It will be important for HSPs to use standardized tools to
measure patient improvement and outcomes in order to complement the service utilization and patient experience data.

- **The Community Rehab Assessment may not be the right tool in its current form for collecting standardized data on patient functional outcomes, but the need for outcome data remains.**

  Results from the phase II CRA pilot are consistent with those of Phase I: the CRA is effective at detecting changes in functional impairment across populations and in high- and low-functioning patients. However, clinicians continued to find completion of the CRA duplicative. This may suggest that the CRA could replace current assessment tools and provide the necessary standardization to allow comparison of outcomes. Clinicians also noted that it added time to appointments, which would be expected with any new tool/process.

  The CRA is a robust tool with demonstrated functionality in detecting patient outcomes across a broad range of patient populations. However, broader uptake and implementation cannot proceed until barriers are addressed. Efforts to advance this work would benefit from a recommendation or direction from the MOHLTC to include a functional outcome tool as part of any future bundled funding pilots or rollouts.

**IMPACT/VALUE**

Implementing the minimum dataset in outpatient rehabilitation addresses a long-standing gap in data needed to demonstrate the value of outpatient rehabilitation in a patient’s health journey.

Infrastructure is now in place for the reporting of outpatient rehabilitation utilization and patient experience data across all populations and regions, and providers have a better understanding of outpatient rehabilitative care resource utilization to inform planning, resource allocation and performance management.

**TOOLS/RESOURCES TO SUPPORT IMPLEMENTATION**

- [Rehabilitative Care Alliance Outpatient Ambulatory Provincial Proof of Concept - Phase I Report](#)
- [[WatLX™ tool](#); [WatLX™ information sheet](#); contact information for WatLX™ developers]
- [Updated NACRS Clinic Lite data elements](#)
- [Bundled funding community of practice (Quorum)](#)
- RCA provincial webinar on the Outpatient/Ambulatory Rehabilitative Care Minimum Data Set and the CRA Phase II pilot: [presentation](#) and [audio recording](#)
- [RCA provincial webinar on NACRS Clinic Lite data collection](#)
“Through the RCA’s leadership, we now have – for the first time – standardized data on outpatient rehabilitation activity and outcomes in Ontario. This data is already being used in policy through the bundled care pilots, and will be crucial for efforts to integrate funding, planning and quality measurement across the entire patient journey.”

Erik Hellsten
Manager of Strategy, Quality Standards
Health Quality Ontario
The RCA’s Patient/Caregiver Advisory Group provided important input to RCA initiatives to ensure they incorporated the perspective of patients and families.

The 15 advisory group members are drawn from nine LHINs and all have experience with rehabilitative care as patients/clients or in their role as family caregivers. The group met nine times over the past two years to review the progress of the initiatives and provide feedback.

Input from the advisory group was particularly important in shaping the following RCA initiatives:

- **Frail Seniors**: The advisory group provided valuable feedback on the draft pathways for older adults who fall, recommending that the focus shift to “what” needs to happen for the patient rather than “who” should perform the task. The resulting revisions strengthen patient-centred care and will support broader uptake by allowing regional providers to determine how best to implement the pathways based on their staffing complement.

- **Capacity Planning**: Patients and caregivers with experience of a hip fracture worked closely with clinical experts to develop the needs-based capacity planning approach for hip fracture. The approach ensures future resource planning takes into account what services and support an individual with a hip fracture needs in each phase of care.

- **Outpatient Reporting**: The advisory group contributed to the final design of two of the three tools now being used to gather standardized, comparable outpatient data across the province. The input ensured that the patient experience survey tool is easier for patients/caregivers to fill out and improved the clarity of the patient outcomes tool used by both patients and clinicians.

An advisory committee member also presented at the RCA’s 2018 provincial forum, highlighting the perspective of the patient/caregiver and the role of the advisory group.

“**I applaud the province in responding to the dire need for rehabilitative care with the creation of the Rehabilitative Care Alliance. Working with the RCA on what this care should look like has been onerous, but the rewards and improved quality of life are found in our stories today and those of our caregivers. Well done!**”

Jennifer Wolfenden
Patient/Caregiver Advisory Group
How the RCA works

The RCA was established by Ontario’s LHINs in 2013 to improve rehabilitative care across the province. As a result of their collaborative efforts, the RCA and its stakeholders have made significant progress in strengthening and standardizing rehabilitative care through better planning, improved performance management and evaluation and the integration of best practices across the care continuum.

SECRETARIAT

An important factor in this success is the infrastructure support provided by the GTA Rehab Network, a recognized leader in improving and planning the delivery of rehabilitation care.

The RCA’s small secretariat team provides project management, conducts reviews of literature and evidence-based practice, analyzes data, engages and consults with key stakeholders from across the province, supports the RCA’s task and advisory groups, and ensures the successful completion of all RCA deliverables on time and on budget. The secretariat is accountable to the RCA Steering Committee.

GOVERNANCE

The RCA is funded by the LHINs. Its governance model (Figure 7) engages provincial stakeholders and rehabilitative care providers from across the continuum and reports to the LHIN CEOs through the following structure:

- **RCA Steering Committee**
  
  The 27-member RCA Steering Committee (Appendix A) meets quarterly and is made up of leaders from health care organizations across the province. The steering committee provides direction and oversight to operational issues and regularly reviews progress against deliverables to ensure the RCA fulfills its contract with the LHINs. The committee is accountable to the LHIN CEOs through its co-chairs, Donna Cripps and Dr. Peter Nord.

- **Task and Advisory committees**
  
  The work of the RCA is advanced through 15 task and advisory groups (Appendix B) aligned with the RCA initiatives. The members of these groups are recruited through an “expression of interest” process that has generated an enthusiastic province-wide response. Members are drawn from HSPs across the province and are selected to create a balance of perspectives, taking into account clinical background and expertise, geographic region, organization type and sector.

  Task groups meet monthly to advance the objectives of the respective initiative, while the advisory groups meet quarterly to receive updates on the task group directions and to provide feedback on these directions. The groups bring a true provincial focus to the work of the RCA,
and through their formal and informal engagement of other stakeholders, they ensure all initiatives address the needs and realities of LHINs, providers and patients across the system.

A Patient/Caregiver Advisory Group (Appendix C) with representation from nine of the LHINs provides insights to inform the work of the RCA.

*Figure 7: Rehabilitative Care Alliance Governance Structure*
As the RCA begins its new three-year mandate and work plan on April 1, 2019, it will continue to build on the progress of existing initiatives, while addressing emerging priorities within the health care system.

Areas of specific focus include the following:

- **Frail Seniors**: Continue to support efforts to reduce preventable emergency department visits and maintain and improve the functional status of community-based frail seniors who fall.

- **Capacity Planning**: Support regions in applying a standardized, needs-based approach to capacity planning for rehabilitative care so that resources are optimally allocated to address patient needs.

- **Bundled Funding**: Continue to work with the MOHLTC and rehabilitative care service providers to support expansion of bundled funding models.

- **Hip Fracture/TJR QBP Best Practices**: Increase alignment across the province with hip fracture and TJR rehabilitative care best practices to support implementation and the spread of the MOHLTC hip & knee bundled funding initiative.

- **Community-Based Rehabilitation**: Improve understanding of how community-based rehabilitative care models could be used to support enhanced patient outcomes, better flow and improved patient transitions.

- **System Evaluation**: Continue to standardize evaluation of rehabilitative care services at the regional and provincial level to support evidence-based practice and system-wide improvement.

- **Definitions**: Continue to guide and support the spread and integration of the definitions frameworks to drive standardization across the province.

- **Assess & Restore**: Analyze provincial outcomes of Assess & Restore funding to illustrate impact on clinical outcomes and system efficiencies.

“**The RCA is a highly effective and efficient organization. I trust the RCA to consult appropriately with stakeholders, set clear objectives, stick to established timelines and deliver results.”**

“**The RCA is a small investment toward the important goal of moving rehabilitative care forward as part of improving the larger health care system in Ontario.”**

Stakeholder comments from RCA Evaluation Survey
From the beginning, the RCA’s strength has been the tremendous engagement and support of stakeholders from across the province. Together with these stakeholders, the RCA will continue to take collective, coordinated action to strengthen and standardize rehabilitative care and bring about system change.
Acknowledgements

GTA Rehab Network

In all its initiatives, the Rehabilitative Care Alliance continues to rely on the leadership and expertise of the GTA Rehab Network and its secretariat. The Network’s previous work in the rehabilitation sector laid the foundation for the RCA, and the Network’s extensive knowledge and established stakeholder relationships have been critical to the RCA’s success.

Expert support

The RCA also depends on the expertise and support of a great many individuals across the province. Many served on the RCA’s task and advisory groups and are listed in the appendices. The RCA would particularly like to thank the following chairs for their time and leadership:

RCA Steering Committee: Donna Cripps and Dr. Peter Nord
Assess & Restore Frail Senior Advisory Group: Dr. Jo-Anne Clarke
Definitions Advisory Group: Mark Edmonds (to March 2018) and Andrea Lee
Frail Seniors Task Group: Dr. Jo-Anne Clarke
Outpatient/Ambulatory Advisory Group: Marie Disotto-Monastero and Michael Gekas
Outpatient/Ambulatory NACRS Working Group: Marie Disotto-Monastero and Michael Gekas
QBP Best Practice Advisory Group: Debra Carson
QBP Best Practice Task Group: Debra Carson
System Evaluation Advisory Group: Imtiaz Daniel

In addition, the RCA would like to thank the following:

- Capacity planning initiative: Dr. Matthew Meyer, epidemiologist and assistant adjunct professor at the Schulich School of Medicine and Dentistry
- Community Rehab Assessment: Dr. Luke Turcotte and Dr. Katherine Berg
- Communications: Linda Huestis
- CRA Phase II Pilot: Participating organizations
- Outpatient/ambulatory provincial proof of concept data entry: Shristi Karim
- System Evaluation:
  - Scorecard development: Melissa Chang
  - Scorecard analytical support: Melissa Marlow
  - Falls data: Erie St. Clair LHIN decision support team, including Pete Crvenkovski, Director, Performance Quality and Knowledge Management; and Clifford Ekwempe, Epidemiologist/Data Analyst
• Data quality review: Lia Salam-White, Hamilton Niagara Haldimand Brant LHIN and participants from Hamilton Niagara Haldimand Brant LHIN, Champlain LHIN, Central East LHIN, Central LHIN, Central West LHIN, Mississauga Halton LHIN, North West LHIN and South West LHIN

• thehealthline.ca Information Network for their work in developing www.rehabcareontario.ca, with special thanks to:
  o Bridget Morant, Project Coordinator
  o Neil Tuomi, Information Systems Manager
  o Gabriele Davey, Product Development Manager
  o Vivette Martin, Learning, Development and Scheduling Support
  o Jennifer Jones, Information Services Manager
  o Ian Hicks, Project Coordinator

• TJR/Hip Fracture Self-Assessments: Participating organizations

The Rehabilitative Care Alliance acknowledges data obtained from the Ontario Ministry of Health and Long-Term Care: IntelliHEALTH ONTARIO.

The views expressed in this report are the views of the RCA and do not necessarily reflect those of the Government of Ontario or the Ministry of Health and Long-Term Care.
## APPENDIX A – RCA STEERING COMMITTEE AND RCA STAFF

| Co-Chair: Donna Cripps          | Hamilton Niagara Haldimand Brant LHIN                                      |
| Co-Chair: Dr. Peter Nord        | Providence Healthcare - Unity Health Toronto                               |
| Lisa Levin                      | AdvantAge Ontario                                                          |
| Aruna Mitra                     | Central West LHIN Home and Community Care                                  |
| David Heaton                    | Closing the Gap Healthcare                                                 |
| Dr. Paul Oh                     | CorHealth & Toronto Rehab - University Health Network                      |
| Erik Hellsten                   | Health Quality Ontario                                                     |
| Heather Binkle/Jennifer Ho      | Health Shared Services Ontario                                             |
| Diane Savage                    | Holland Bloorview Kids Rehabilitation Hospital                             |
| Barry Monaghan                  | Member at Large                                                            |
| Karina Baylon                   | Ministry of Health and Long-Term Care                                      |
| Dr. Jo-Anne Clarke              | North East Specialized Geriatric Centre                                     |
| Imtiaz Daniel                   | Ontario Hospital Association                                               |
| Enza Ferro                      | Ontario Hospital Association                                               |
| Vinita Haroun                   | Ontario Long Term Care Association                                         |
| Dorianne Sauvé                  | Ontario Physiotherapy Association/Ontario Society of Occupational Therapists/Ontario Association of Speech-Language Pathologists & Audiologists |
| Kelly Milne                     | Regional Geriatric Program of Eastern Ontario                               |
| Dr. Barbara Liu                 | Regional Geriatric Program of Toronto                                      |
| Michael Gekas                   | Sinai Health System - Bridgepoint                                           |
| Tracy Buckler                   | St. Joseph's Care Group - Thunder Bay                                      |
| Roy Butler                      | St. Joseph's Health Care - London                                           |
| Andrea Lee                      | St. Joseph's Health Care - London                                           |
| Marie Disotto-Monastero         | Sunnybrook Health Sciences Centre - St. John's Rehab                       |
| Dr. Shawn Marshall              | The Ottawa Hospital                                                        |
| Frederic Beauchemin             | The Ottawa Hospital                                                        |
| Debra Carson                    | Trillium Health Partners                                                   |
| Donald Sanderson                | West Parry Sound Health Centre                                             |

### Rehabilitative Care Alliance Secretariat

| Executive Director             | Charissa Levy                                                              |
| Office Manager                  | Karen Allison                                                              |
| Project Manager                 | Sue Balogh                                                                 |
| Project Manager                 | Rebecca Ho                                                                 |
| Project Manager                 | Gabrielle Sadler                                                           |
APPENDIX B – RCA TASK AND ADVISORY GROUPS

Assess & Restore Frail Senior Advisory Group

Chair: Dr. Jo-Anne Clarke
Project Lead: Gabrielle Sadler

North East Specialized Geriatric Centre
Rehabilitative Care Alliance

Henza Miller
Baycrest Health Sciences

Lori Leighton
Brant Community Healthcare System

Sandra Iafrate
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Aruna Mitra
Central West LHIN Home and Community Care

Jeanne Bonnell
Champlain LHIN Home and Community Care

Dale Mayerson
Dietitians of Canada

Jennifer Buccino
Dietitians of Canada

Helen Johnson
Erie St. Clair LHIN

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Jane Keppy
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Harrow Health Centre Inc.

Colleen Bronicheski
Health Sciences North

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Mary Evoy
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Kim Smith
Kingston Health Sciences Centre

Dr. Kevin Willison
Lakehead University

Amy Maebrae-Waller
Lakeridge Health

Josh Theodore
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Julie Langton
Lakeridge Health

Tim Rice
London Health Sciences Centre - Victoria Hospital

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Mississauga Halton LHIN

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North Simcoe Muskoka LHIN

Tamara Nowak-Lennard
North Simcoe Muskoka Specialized Geriatric Services

Karen Truter
Northumberland Hills Hospital

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Judy Porteus
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Julie Cordasco
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Bonny O’Hare
Pro Motion Physiotherapy and Osteo-Circuit

Caryn Langstaff
Providence Care

Jacqueline Lumsden
Providence Healthcare - Unity Health Toronto

Jessica Casey
Providence Healthcare - Unity Health Toronto
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<td>Vanina Dal Bello-Haas</td>
<td>School of Rehabilitation Science, McMaster University</td>
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<td>Judy Chu</td>
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<td>Scott Thomas</td>
<td>University of Toronto/Faculty Kinesiology Physical Education</td>
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<td>University of Western Ontario - School of Physical Therapy</td>
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<td>Kimberley Day</td>
<td>West Park Healthcare Centre</td>
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Debbie Junk-Lloyd  West Parry Sound Health Centre
Annabelle Bryden  Woodgreen Community Services
Valerie Arseneau  Woodgreen Community Services
Sean Willis  Woodstock Hospital

**Capacity Planning Advisory Group**

Chair: Charissa Levy  Rehabilitative Care Alliance
Project Lead: Rebecca Ho  Rehabilitative Care Alliance

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Farrah Hirji  Central East LHIN
Aruna Mitra  Central West LHIN Home and Community Care
Helen Johnson  Erie St. Clair LHIN
Kim Young  Hamilton Niagara Haldimand Brant LHIN
Amy Khan  Mississauga Halton LHIN
Jennifer Wallenius  North East LHIN
Susan Gibb  North Simco Muskoka LHIN
Wendy McAllister  North West LHIN
Florence Peretie  South East LHIN
Shirley Koch  South West LHIN
Fred Beauchemin  Champlain LHIN
Heather McKenna  Champlain LHIN
Victoria Williams  Toronto Central LHIN
Sheila Banks-Switzer  Toronto Central LHIN
Zach Weston  Waterloo Wellington LHIN

**Capacity Planning Task Group**

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Project Lead: Rebecca Ho  Rehabilitative Care Alliance

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Helen Johnson  Erie St. Clair LHIN
Kim Young  Hamilton Niagara Haldimand Brant LHIN
Jennifer Wallenius  North East LHIN

**Capacity Planning Clinical and Patient Subject Matter Expert Panel**

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Project Lead: Rebecca Ho  Rehabilitative Care Alliance

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Anne Harley  Bruyère Continuing Care
Jacqueline Minezes  Central West LHIN Home and Community Care
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Jeanne Bonnell
Alka Sahadath
Helen Johnson
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Kate Trihey
Leslie Gillies
Mary Lou Myers
Jennifer Fife
Kim Young
Janet McMullan
Melissa Aldoroty
Eve-Ann Reid
Pat Messner
Ursula Gruber
Susan Bedell
Ken Hoard
Amanda Longfield
Denise Taylor
Andrea Bishop
Leanne Bradbury
Nancy Bovell
Patricia Dickson
Teresa So Mei Yeung

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Community Advantage Rehabilitation
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Patient Advisor, Central East LHIN
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St. Joseph’s Healthcare - Hamilton
St. Joseph’s Healthcare - Hamilton
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West Park Healthcare Centre

Definitions Advisory Group

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Benjamin McNamee
Farrah Hirji
Carl Bonura
Chantelle Vernon
Julie Sullivan
Kimberly Floyd
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Halton Healthcare
Hamilton Health Sciences
Hamilton Niagara Haldimand Brant LHIN
Health Sciences North
Lakeridge Health
Mississauga Halton LHIN
Muskoka Algonquin Healthcare
North Bay Regional Health Centre
Jennifer Wallenius          North East LHIN
Dana Corsi               North East Specialized Geriatric Centre
Susan Gibb              North Simcoe Muskoka LHIN
Wendy McAllister        North West LHIN
Caryn Langstaff         Providence Care
Florence Peretie         South East LHIN
Shirley Koch            South West LHIN
Carolyn Freitag          St. Joseph's Care Group - Thunder Bay
Denise Taylor           St. Joseph's Care Group - Thunder Bay
Kathy Tschirhart        St. Joseph’s Health Centre - Guelph
Beth Donnelly           The Ottawa Hospital/Rehab Network of Ottawa/Champlain LHIN
Fred Beauchemin        The Ottawa Hospital/Rehab Network of Ottawa/Champlain LHIN
Heather McKenna         The Ottawa Hospital/Champlain LHIN
Victoria Williams       Toronto Central LHIN
Joanne Zee              University Health Network - Toronto Rehab
Zach Weston             Waterloo Wellington LHIN
Bonnie Camm             William Osler Health System

HSP Definitions Implementation Group

Chair: Charissa Levy          Rehabilitative Care Alliance
Project Lead: Sue Balogh       Rehabilitative Care Alliance

Bidarekere Swamy           Berkshire Care Centre
Amanda Ross                Bluewater Health
Bob DeRaad                 Bluewater Health
Jenn Mackey                Bluewater Health
Paula Gilmore              Bluewater Health
Travis Wing                Brockville General Hospital
Benjamin McNamee           Central East LHIN
Jarrod Prieur              Chatham Kent Health Alliance
Kimberly Smith             Chatham Kent Health Alliance
Shane Helgerman            Chatham Kent Health Alliance
Michelle Stroud            Durham Christian Homes – Glen Hill Strathaven
Helen Johnson              Erie St. Clair LHIN
Laura Watling              Grand River Hospital
Joan Ruston-Berge          Grey Bruce Health Services
Rob Young                  Groves Memorial
Genny Cho                  Halton Healthcare
Helen Schelfhaut           Halton Healthcare
Julie Lau                  Halton Healthcare
Leslie Gillies             Hamilton Health Sciences
Rebecca Fleck              Hamilton Health Sciences
Teri Czajka                 Hamilton Health Sciences
Mary Wheelwright           Headwaters Health Care Centre
Elaine Widgett  Holland Bloorview Kids Rehabilitation Hospital
Chris Pollard  Hotel Dieu Shaver Health and Rehabilitation Centre
Eleanor Groh  Hôtel-Dieu Grace Healthcare
Shelley Toth  Hôtel-Dieu Grace Healthcare
Cheryl Gustafson  Joseph Brant Hospital
Christine Hnatiuk  Joseph Brant Hospital
Josh Theodore  Lakeridge Health
Nancy Jones  Lakeridge Health
Lorianne Granger  Leamington District Memorial Hospital
Lucie Fontaine  Maple Health Centre
Shelley Dobson  Meritas Care Corporation
Brenda McCulla  Newmarket Health Centre
Patty Byers  North Bay Regional Health Centre
Karen Raybould  North East LHIN Home and Community Care
Mary Tasz  North East LHIN Home and Community Care
Dana Corsi  North East Specialized Geriatric Centre
Peter Dilworth  North Hamilton Community Health Centre
Ryan Miller  Orillia Soldiers’ Memorial Hospital
Beth Brownlee  Pembroke Regional Hospital
Colleen Armstrong  Peterborough Regional Health Centre
Tamara Lucas  Peterborough Regional Health Centre
Caryn Langstaff  Providence Care
Kelly Tough  Providence Healthcare - Unity Health Toronto
Paulette Gardiner Millar  pt Health
Derk Damron  Quinte Health Care
Linda Calabrese  Responsive Management, Berkshire Care Centre
Leslie Burch  Sault Area Hospital
Trixie Williams  Scarborough Health Network
Greg Almas  Shalom Village
Krista Sheppard  Shalom Village
Kari Gervais  St. Joseph’s Continuing Care Centre
Carolyn Freitag  St. Joseph’s Care Group - Thunder Bay
Kathleen Lynch  St. Joseph’s Care Group - Thunder Bay
Denise Taylor  St. Joseph’s Care Group - Thunder Bay
Leesa McNally  St. Joseph’s Continuing Care Centre - Cornwall
Andrea Lee  St. Joseph’s Health Care - London
Kathy Tschirhart  St. Joseph’s Health Centre - Guelph
Wayne Lew  St. Joseph’s Health Centre - Guelph
Amanda Weatherston  St. Joseph’s Healthcare - Hamilton
Shelley Huffman  Stroke Network of Southeastern Ontario
Jake Tran  Toronto Grace Health Centre
Josh Moralejo  Toronto Grace Health Centre
Maria De Leon  Toronto Grace Health Centre
Lynn Roberti  Trillium Health Partners
Kim Van Dam  Trillium Villa Long Term Care
Joanne Zee  University Health Network - Toronto Rehab
Tammy Unwin  Vision Nursing Home
Frail Seniors Task Group

Chair: Dr. Joanne Clarke  
Project Lead: Gabrielle Sadler  
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Rehabilitative Care Alliance

Jeanne Bonnell  
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Jenn McDonald  
Community Support Connections - Meals on Wheels and More

Dale Mayerson  
Dietitians of Canada

Helen Johnson  
Erie St. Clair LHIN

Jana McIntyre  
Erie St. Clair LHIN

Margo Reilly  
Harrow Health Centre Inc.: A Family Health Team

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Nancy Berthiaume  
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Sonya Vani  
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Brandi Flowers  
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Cindy Emeljanow  
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Mari Schlorff  
Orillia Soldiers’ Memorial Hospital

Caryn Langstaff  
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Jessica Casey  
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The Ottawa Hospital

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Judy Chu  
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Paula van Wyk  
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Andrea Cameron  
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Khrista Boon  
Victorian Order of Nurses

Katie Smith  
Waterloo Wellington LHIN Home and Community Care

Debbie Junk-Lloyd  
West Parry Sound Health Centre
## Frail Senior ECHO Working Group

<table>
<thead>
<tr>
<th>Chair: Charissa Levy</th>
<th>Rehabilitative Care Alliance</th>
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<tr>
<td>Dr. David Conn</td>
<td>Baycrest Health Sciences</td>
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<td>Lisa Sokoloff</td>
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## LHIN Leads Advisory Group

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## Outpatient/Ambulatory Advisory Group

<p>| Co-Chair: Marie Disotto-Monastero | Sunnybrook Health Sciences Centre - St. John's Rehab |
| Co-Chair: Michael Gekas          | Sinai Health System - Bridgepoint |
| Project Lead: Rebecca Ho         | Rehabilitative Care Alliance     |
| Marie Graham                     | Bayshore HealthCare Ltd.        |
| Anne Mantha                      | Bruyère Continuing Care         |
| Elizabeth MacDonald/Ryan Metcalfe| Canadian Institute for Health Information |
| Nawaf Madi                       | Canadian Institute for Health Information |</p>
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<td>Stroke Network of Southeastern Ontario</td>
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<tr>
<td>Amy Wainwright</td>
<td>Sunnybrook Health Sciences Centre</td>
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<tr>
<td>Esme French</td>
<td>Northwestern Ontario Regional Stroke Network</td>
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<tr>
<td>Joanne Zee</td>
<td>University Health Network - Toronto Rehab</td>
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<td>Raghad Zaiyouna</td>
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<td>Woodstock Hospital</td>
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**Outpatient/Ambulatory NACRS Working Group**

| Co-Chair: Marie Disotto-Monastero | Sunnybrook Health Sciences Centre |
| Co-Chair: Michael Gekas           | Sinai Health System - Bridgepoint Health |
| Project Lead: Rebecca Ho          | Rehabilitative Care Alliance       |

| John Wright                     | Atikokan General Hospital           |
| Michelle Sophie                 | Durham Physiotherapy Clinic         |
| Sharon Ocampo-Chan              | GTA Rehab Network                   |
| Maureen Hutley                  | Hamilton Health Sciences            |
| Charline Boudreau               | Montfort Hospital                   |
| Hélène Manning-Lemieux          | Montfort Hospital                   |
| Kelly Tough                     | Providence Healthcare - Unity Health Toronto |
| Shelby Poletti                  | St. Joseph’s Care Group - Thunder Bay |
| Scott Munro                     | St. Joseph’s Care Group - Thunder Bay |
| William Cachia                  | University Health Network - Toronto Rehab |
| Shirley Price                   | West Park Healthcare Centre         |

**Post-Fall Rehabilitative Care Pathway - External Stakeholder Reviewers**

<p>| Project Lead: Gabrielle Sadler  | Rehabilitative Care Alliance         |
| Ashley Hurley                   | City of Lakes Family Health Team     |</p>
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<tr>
<td>Colleen O’Neill</td>
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<tr>
<td>Martha Bauer</td>
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<tr>
<td>Katrina Radassao</td>
<td>Nipigon District Memorial Hospital</td>
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<td>Alexandra Schmidt</td>
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<tr>
<td>Dr. Debra Eagles</td>
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<tr>
<td>Dr. Eoghan O’Shea</td>
<td>Primary Care Physician</td>
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<tr>
<td>Dr. Therese Hodgson</td>
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<tr>
<td>Julia Filinski</td>
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<td>Jeff Kestenberg</td>
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<td>Brianna Reed</td>
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<td>Peggy So</td>
<td>Providence Healthcare - Unity Health Toronto</td>
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<tr>
<td>Christine Bradshaw</td>
<td>Sinai Health System</td>
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<td>Dr. Don Melady</td>
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<td>Matt Royal</td>
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<td>Dr. Brittany Ellis</td>
<td>Sinai Health System/University of Ottawa</td>
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<td>Peggy Bosanac</td>
<td>St. Joseph’s Healthcare – Hamilton</td>
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<td>Michelle Strong</td>
<td>McCausland Hospital – North of Superior Healthcare Group</td>
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<td>Val Walser</td>
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<td>Emily Stevenson</td>
<td>Toronto Central LHIN</td>
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<tr>
<td>Dr. Teresita Hogan</td>
<td>University of Chicago</td>
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**QBP Best Practice Advisory Group**

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<tr>
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<td>Chair: Debra Carson</td>
<td>Trillium Health Partners</td>
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<tr>
<td>Project Lead: Gabrielle Sadler</td>
<td>Rehabilitative Care Alliance</td>
</tr>
<tr>
<td>Sylvia Davidson</td>
<td>Baycrest Health Sciences</td>
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<tr>
<td>Dana Vanderaa</td>
<td>Bluewater Health</td>
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<tr>
<td>Jenini Subaskaran</td>
<td>Bruyère Continuing Care</td>
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<tr>
<td>Kathy Greene</td>
<td>Bruyère Continuing Care</td>
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<td>Carl Bonura</td>
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<td>Jeanne Bonnell</td>
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<td>Jo-Anne Desroches</td>
<td>Closing the Gap Healthcare</td>
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<td>Lee Masse</td>
<td>Closing the Gap Healthcare</td>
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<tr>
<td>Alka Sahadath</td>
<td>Community Advantage Rehabilitation</td>
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<td>Helen Johnson</td>
<td>Erie St. Clair LHIN</td>
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<tr>
<td>Sharon Ocampo-Chan</td>
<td>GTA Rehab Network</td>
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<tr>
<td>Daniel Ball</td>
<td>Halton Healthcare</td>
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<td>Jody Strik</td>
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<tr>
<td>Leslie Gillies</td>
<td>Hamilton Health Sciences</td>
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<tr>
<td>Maureen Hutley</td>
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</table>
Colleen Bronicheski  Health Sciences North  
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Josh Theodore  Lakeridge Health  
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Shirley Price  West Park Healthcare Centre  
Teresa So Mei Yeung  West Park Healthcare Centre  
Jennifer Santos  William Osler Health System  
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Sean Willis  Woodstock Hospital

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West Parry Sound Health Centre  
West Park Healthcare Centre  
William Osler Health System  
York University
APPENDIX C – PATIENT/CAREGIVER ADVISORY GROUP

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Project Lead: Sue Balogh
Project Lead: Rebecca Ho
Project Lead: Gabrielle Sadler

Rehabilitative Care Alliance
Rehabilitative Care Alliance
Rehabilitative Care Alliance
Rehabilitative Care Alliance

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Eve-Ann Reid
Robert Craft
Paul Fehrenbach
Peter Ashby
Jill Chalmers
Jennifer Walkes
Jeff Wolfenden
John Stephens
Brenda Murray
Betty Anne Nurse
Karen Regier
Katie Harris
Cathie Singer
Chris Stigas

Central East LHIN
Central East LHIN
Champlain LHIN
Champlain LHIN
Erie St. Clair LHIN
Erie St. Clair LHIN
Hamilton Niagara Haldimand Brant LHIN
Hamilton Niagara Haldimand Brant LHIN
North East LHIN
North Simcoe Muskoka LHIN
North West LHIN
South West LHIN
Toronto Central LHIN
Toronto Central LHIN
Toronto Central LHIN
APPENDIX D – EMERGENCY DEPARTMENT: PATHWAY TO REHABILITATIVE CARE FOR FRAIL OLDER ADULTS POST-FALL

This pathway is considered draft pending pilot of the pathway in 2019/20.

Pathway to rehabilitative care for frail older adults in the community presenting to Emergency Department post-fall and not requiring acute hospitalization

Emergency Department

- Older adult reports fall(s) or presents immediately following a fall

Definition: A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. World Health Organization

- 2 or more falls in the last year?

- High Risk for Functional Decline

- Multifactorial Evaluation
  - Determine risk factors for secondary fall
  - Assess level of frailty: eg. Clinical Frailty Scale (CFS)*
  - Use interdisciplinary team approach. Refer to GEM Nurse, PT, OT, SW, RD as appropriate

- Community Intervention
  - Explore Direct Access to Inpatient Rehabilitative Care
  - Explore direct referral to inpatient rehabilitative care services, where available (wait at home for admission, if safe to do so)

- Outpatient Ambulatory/In Home Care/Specialized Geriatric Services
  - Referrals for rehab services to address risk factors identified
  - Redirect to Primary Care Practitioner
  - Consider referral to: Home & Community Care
  - Publicly funded rehabilitative care service listing: www.rehabcareontario.ca
  - Consider privately funded rehabilitation options

- Community Intervention
  - Referrals for rehab services to address risk factors identified
  - Redirect to Primary Care Practitioner
  - Consider referral to: Home & Community Care
  - Outpatient Ambulatory Rehabilitative Care Services
  - Specialized Geriatric Services, if available
  - Publicly funded rehabilitative care service listing: www.rehabcareontario.ca
  - Consider privately funded rehabilitation options

- MONITORING & FOLLOW-UP IN PRIMARY CARE: Communicate results of preliminary evaluation and referral pathway to primary care provider.

*Older adults who experience a fall are likely to have multiple conditions and complex health needs. Preventing functional decline and further falls among high-risk older adults requires an integrated, coordinated approach to care.

APPENDIX E – PRIMARY CARE: PATHWAY TO REHABILITATIVE CARE FOR FRAIL OLDER ADULTS POST-FALL

This pathway is considered draft pending pilot of the pathway in 2019/20.

Pathway to rehabilitative care for frail older adults in the community presenting to Primary Care post-fall

Primary Care

Older adult reports fall(s) or presents immediately following a fall

Definition: A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. (World Health Organisation)

Older adults who experience a fall are likely to have multiple conditions and complex health needs. Preventing functional decline and further falls among high risk older adults requires an integrated, coordinated approach to care.

Immediately following a fall:

- Assess severity of injury
- Rule-out acute medical conditions
- Injuries may be occult or present atypically

Secondary visit: Multifactorial Evaluation

- Assess level of frailty: eg. Clinical Frailty Scale (CFS)*
- Conduct fracture risk assessment
- If available in your setting, use interdisciplinary team approach or telemedicine

- Not frail
  - eg. CFS 1-3
  - Few fall risk factors
  - Not medically complex
- Mild to moderate frailty, eg. CFS 4-6
  - Multiple fall risk factors
  - Reasonably mobile
- Mild to moderate frailty, eg. CFS 4-6
  - Multiple fall risk factors and/or medically/psychosocially complex
- Mild to moderate frailty, eg. CFS 4-6
  - Multiple fall risk factors and/or medically complex
  - No other reasonable means of rehabilitative care

Multiple Fall Risk factors, including:

- Alcohol Intake
- Cognition
- Feet/Foot Wear
- Hearing
- Home Hazards
- Inactivity/sedentary
- Incontinence
- Medication
- Mobility/Balance
- Mood
- Nutrition & Hydration
- Orthostatic Hypotension
- Polypharmacy
- Vestibular Conditions
- Vision

"All domains are assessed together to inform a comprehensive plan of care"

Outpatient Ambulatory/In Home Care

Specialized Geriatric Services

Explore Direct Access to Inpatient Rehabilitation

Referrals to rehab services to address risk factors identified

Publicly funded rehabilitative care service listing:

www.rehabcareontario.ca

Consider privately funded rehabilitation options

Referrals to rehab services to address risk factors identified

Consider additional referrals to:

Home & Community Care Outpatient Ambulatory Rehabilitation Care Services

Publicly funded rehabilitative care service listing:

www.rehabcareontario.ca

Consider privately funded rehabilitation options

Referral to Specialized Geriatric Services, if available

Publicly funded rehabilitative care service listing:

www.rehabcareontario.ca

Explore direct referral to inpatient rehabilitative care services, where available

Publicly funded rehabilitative care service listing:

www.rehabcareontario.ca

Please note that some patients may require some or all of these services throughout their post-fall journey. The intent of this pathway is to depict the services initially required based on their preliminary evaluation.

MONITORING & FOLLOW-UP IN PRIMARY CARE: Monitor progress against the care plan. Patient progress and reassessment results are communicated across care partners.
### APPENDIX F – ACRONYMS

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<th>Description</th>
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<td>Assess &amp; Restore</td>
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<td>Direct Access Priority Process</td>
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To learn more about the Rehabilitative Care Alliance, please visit rehabcarealliance.ca