Rehabilitative Care Alliance

Community-Based Rehabilitation: Providing High-Value Rehabilitative Care in the Community

Part 1: The Value of Community-Based Rehabilitation: An Overview

November 2020

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ABOUT THIS WHITE PAPER

This is Part 1 of a four-part white paper that explores the critical role that community-based rehabilitation plays in the Ontario health care system. *Community-Based Rehabilitation: Providing High-Value Rehabilitative Care in the Community* describes the impact of community-based rehabilitation and provides recommendations for health system decision-makers in order to improve the spread of innovative and cost-effective community-based models of rehabilitative care.

Community-Based Rehabilitation: Providing High-Value Rehabilitative Care in the Community will be released in four parts:

Part 1: The Value of Community-Based Rehabilitation: An Overview

Part 2: In-Home Rehabilitation *(available now)*

Part 3: Ambulatory-Based Rehabilitation *(available spring 2021)*

Part 4: Rehabilitative Care in Primary Care *(available fall 2021)*

INTRODUCTION

Rehabilitative care is an essential component of patient-centered, integrated care. Evidence shows that rehabilitation provided along a continuum of care from hospital to home and community can improve health outcomes, reduce costs by shortening hospital stays, reduce disability and improve quality of life for patients and their care partners.[1] [2]

Individuals may require rehabilitative care because of illness, injury, disability, chronic disease or aging. Rehabilitation can include a broad range of interventions that help to restore and maximize functional and cognitive abilities. These interventions help individuals adjust to new functional levels or complex conditions, adapt their skills and reintegrate into the community. Rehabilitative care also contributes to seamless transitions and supports individuals to live successfully in community settings.

To ensure effective rehabilitative care, rehabilitation professionals develop comprehensive, goal-directed plans with individuals and their care partners that assess and address all aspects of a person's needs, including physical, cognitive, communicative and psychosocial issues. Rehabilitation professionals are key members of interprofessional teams and rehabilitative care is integral to bundled models of care for many populations.[3]

Rehabilitation services are essential and need to be maintained as a critical component of high-value care provided to individuals across the lifespan.[4] [5] As Ontario restructures its health care delivery model and continues to respond to the COVID-19 pandemic, it is important to consider how health care models such as community-based rehabilitation can enhance patient outcomes and support efficient and effective delivery of care. This approach aligns with the Ministry of Health's objective of establishing "new models of care across Ontario that will integrate publicly funded health care delivery within

specified geographies, putting each patient at the centre of a connected system of care that is anchored in the community, is actively connected with primary care and home care, and responds to regional differences in needs and capacities."[6]

It is important to note the impact the pandemic has had on the availability of community-based rehabilitative care. The initial pandemic response was largely focused on ensuring adequate capacity to care for people who became critically ill, protecting health care providers and preventing community spread. The result was a significant reduction in many services, including the provision of community-based rehabilitative care. However, as outlined above, rehabilitation services are essential to high-value care, maximizing recovery and maintaining function.[4] [5] Restoring these services must be a priority.

WHAT IS COMMUNITY-BASED REHABILITATION?

In 2015 the Rehabilitative Care Alliance (RCA) released the *Definitions Framework for Community-Based Levels of Rehabilitative Care*.[7] This foundational document defines (1) the levels of rehabilitative care in community-based settings and (2) the recommended standard components and human resources within each level of rehabilitative care.

Community-based rehabilitation is focused on enabling individuals with impairments and disabilities to reach and maintain their optimal physical, sensory, intellectual, communicative, psychological and social functional levels. It promotes health and well-being, re-integration to and participation in community living, and improves quality of life. People across all age ranges and patient populations benefit from community-based rehabilitation, including but not limited to those requiring rehabilitation related to:

- Post-surgical and post-hospital care,
- Musculoskeletal, neurological and cardiorespiratory conditions,
- Cancer and palliative care, and
- Chronic conditions and general deconditioning.

Determination of where a patient receives community-based rehabilitative care (in the community, in-home or in a primary care setting) should be based on which environment is most appropriate and safe given the patient's rehabilitative goals, their preferences and the care partner supports available to them. Other considerations include resource/equipment needs, individual or group format, in-person or virtual care treatment, the capacity and safety of patients to travel outside of the home and availability of services.

Key features of community-based rehabilitation include the following:

- Rehabilitation is provided by or under the supervision of a minimum of one regulated rehabilitative care professional with expertise in providing care for a specific patient population, or by an integrated, inter-professional team of regulated health care professionals who provide

services one-on-one to a group of clients using in-person or virtual formats (or a combination of both) to maximize community integration;

- Rehabilitation goals can be met or reasonably equivalent gains can be achieved:
    - Independently in collaboration with the rehabilitative care provider,
    - With care partner education, training and support, and
    - Through self-care/wellness/health promotion classes;
- Medical care/management may be provided by a primary care provider as well as by those focused on rehabilitative care, and
- Rehabilitative care services are delivered in private or public health care settings.[7]

Although health promotion/prevention programs that are not provided by or supervised under regulated health professionals are not included in this white paper, it is acknowledged that such programs may be integrated into the services provided by regulated health care professionals. In addition, these programs play an important role in the system by promoting overall health and supporting patients' reintegration in the community.[7]

VALUE OF COMMUNITY-BASED REHABILITATION

Why community-based rehabilitation?

With the development of a new Ontario health care structure, there are many questions regarding how to enable the delivery of high-quality health care and services to Ontarians, where and when different types of health services are needed and how to deliver a positive outcome and experience. With these questions comes the need to better understand the role of community-based rehabilitative care in the current health care system and the potential of new, innovative models that support enhanced patient outcomes and more efficient care.[8]

In the first interim report from the Premier's Council on Improving Healthcare and Ending Hallway Medicine, the current state of community-based rehabilitative care in Ontario is highlighted:

> *In general, there are more patients of all ages and abilities with complex rehabilitation and mental health and addictions needs who could benefit from additional support in the community. Given the specific health care needs of an aging population, home care services are now supporting an increasingly complex client base that requires more assistance than before. Although the province has invested significant resources in the past to helping Ontarians stay in their home as they age, these patients are living longer and getting to the point now where they are experiencing a decline in their ability to perform activities of daily living.*[9]

The findings of the report led the Premier's Council to make ten recommendations in its second report, including the following recommendations under the categories of Integration and Innovation:

- *Put patients at the centre of their health care. Ensure patients are well-supported and treated with dignity and respect throughout all interactions with the health care system.*

- *Improve patients' and providers' ability to navigate the health care system, simplify the process of accessing and providing care in the community, and improve digital access to personal health information.*
- *Support patients and providers at every step of a health care journey by ensuring effective primary care is the foundation of an integrated health care system.*
- *Improve options for health care delivery, including increasing the availability and use of a variety of virtual care options.*
- *Modernize the home care sector and provide better alternatives in the community for patients who require a flexible mix of health care and other supports.*[10]

These recommendations clearly indicate the need to explore innovative and integrated community-based models of care that support people to be at the centre of their care, live in their own home and enhance or maintain functional status and quality of life.

Clinical and system benefits

Improving access to community-based rehabilitative care services (including virtual care options) will reduce wait times, avoid emergency department use, reduce inpatient admissions and support earlier inpatient discharge with reduced lengths of stay.[10] [11] [12] [13] [14] [15]

For community-dwelling older adults, rehabilitation provides strategies to remain independent in the community[16] [17] and reduces the risk of falls.[18] People with chronic conditions are supported through self-management techniques to decrease their symptoms, improve their daily function[19] [20] and reduce potential opioid use.[21] Rehabilitation also helps patients with hip fracture, stroke, acquired brain injury, musculoskeletal injury and other conditions to maximize their day-to-day functioning, improve their ability to communicate and improve their quality of life.[22] [23] [24] Cardiac rehabilitation has been shown to reduce patient mortality by 50 per cent.[25] With childhood disability on the rise, community rehabilitative care enables children and youth to learn and develop life skills, be creative and interact with their environment and community.[26] [27] This list is by no means exhaustive, but illustrates that rehabilitative models of care support individual, family and system outcomes within the community.

What are the costs/risks of not providing rehabilitative care?

According to the World Health Organization's (WHO) World Report on Disability,[28] estimating unmet rehabilitation needs is challenging given the current lack of related statistical data. That said, there is empirical research to support that an absence of rehabilitative care services can lead to negative consequences at both the individual and system level.

At an individual level, unmet rehabilitative care needs can limit a person's performance of activities of daily living and level of independence. This in turn may result in an increased dependency on personal support services and essential care partners. Participation in vocational, social and/or recreational activities may also be limited, leading to social isolation, which is associated with higher levels of depression.[29] Without access to rehabilitative care, individuals may also experience deterioration in health and poor overall quality of life.[3] Limited or delayed access to rehabilitative care can result in

further negative consequences. For example, an injury or physical impairment that is not addressed in a timely fashion through rehabilitative care can lead to loss of function, which in turn can lead to further injury, restrictions in the ability to use assistive devices, increased dependency, reduced psychosocial functioning, increased prescription of opioids or hospital admission.[30] [31]

At a system level, the absence of a rehabilitative care approach and interventions will result in longer hospital stays, delays in discharge, increases in alternate level of care (ALC) days and risk of hospital admission and readmission, increased personal support costs and increased care partner burden, all of which contribute to financial and social costs for the system at large.[28]

Where are community rehabilitative care services provided?

Community-based rehabilitation is provided by regulated health care professionals across a variety of public and privately funded settings. These settings include schools, hospital or community-based ambulatory rehabilitation clinics, primary care, private homes/residences and congregate settings (retirement homes, group homes, long-term care). Services can be delivered in-person and, where appropriate, through virtual care options. This helps support flexibility for patients and their care partners. For the purposes of this white paper, models of care will be described in three categories: in-home, ambulatory-based and primary care. These categories are not mutually exclusive as many emerging and innovative models of care span different locations and modes of care, including virtual care. These "mixed models" will be addressed throughout the white paper.

In-home rehabilitative care

Home and community health care is described by the Government of Canada as "services [that] help people to receive care at home, rather than in hospital or long-term care facility, and to live as independently as possible in the community."[32]

Generally, patients who access in-home rehabilitation services are not able to access outpatient services for a variety of reasons, or have rehabilitation goals that are best met in the home setting. These reasons include nature of their condition, cognitive impairment, level of mobility, transportation access and availability of outpatient services. In addition, in-home rehabilitative care models offer home consultations and safety assessments that can be used to support safe transitions from hospital to home. Often, the patient may require a short-term "transition to outpatient from home" service to overcome physical barriers of their home setting (e.g., stairs) to attend ambulatory-based rehabilitative care. In addition, some patient goals may be best met through in-home services provided or supervised by a regulated health care professional or interdisciplinary team, including physiotherapists, occupational therapists, speech-language pathologists, kinesiologists, social workers, dietitians and nurses and physicians, among others. Examples include: 1) assessing and practicing meal preparation in a patient's own home, 2) gait aid or wheelchair prescription, 3) home modification recommendations, and 4) palliative pain and symptom management.

Ambulatory-based rehabilitative care

Ambulatory-based rehabilitative care refers to services provided in a community setting such as publicly funded clinics, private community-based clinics, health centres or ambulatory areas of hospitals. Rehabilitation is provided or supervised by a regulated rehabilitative care professional with expertise to serve the patient population. The regulated health professional often works within the context of an interdisciplinary team, including rehabilitative care professionals such as physiotherapists, occupational therapists, speech-language pathologists, audiologists, kinesiologists, social workers, dietitians and nurses and physicians, among others. Care includes, but is not limited to: consultation, assessment, triage, treatment, equipment prescription and training, self-management and patient and family education. Care can be in-person or virtual and individual or group-based. Patients may also access specialty equipment for assessment or treatment that would not be practical to provide in another setting, such as in-home.

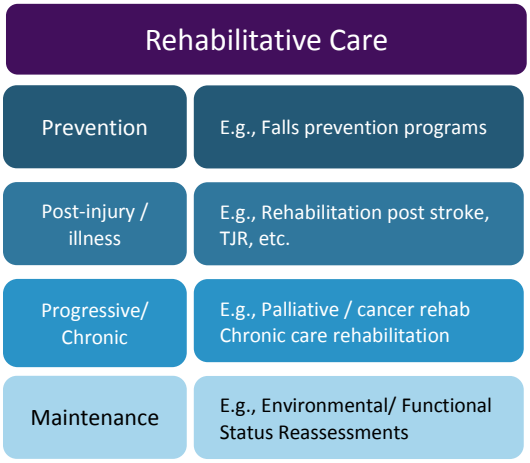
Rehabilitative care in primary care teams

Primary care teams serve as the first point of entry into the health care system for patients rostered to a primary care organization and as the continuing focal point for all their needed health care services. Primary care practices provide health promotion, disease and fall prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses. Primary care teams are organized to meet the needs of patients within the primary care practice itself. Generally located in the patient's community, primary care facilitates access to rehabilitative care while maintaining a wide variety of specialty and institutional consultative and referral relationships for specific care needs. Utilizing an interdisciplinary team approach, primary care teams may include, but are not limited to: family physicians, nurse practitioners, registered nurses, social workers, dietitians, kinesiologists, physiotherapists, occupational therapists and speech-language pathologists.

METHODOLOGY

Community-Based Rehabilitation: Providing High-Value Rehabilitative Care in the Community will be released in four parts. This paper (Part 1) provides an overview of the value of community-based rehabilitation.

In Parts 2 to 4, key best practices and examples of community-based models of care that positively impact patients and system-level outcomes will be identified through a review of the literature and best practice guidelines. Drawing on the evidence, the various types of rehabilitative care will be described using the following patient-centred, needs-based categories, recognizing that patients requiring rehabilitation may fall under more than one category concurrently:



In each category, examples of effective rehabilitative care models will be identified along with their outcomes, addressing the objectives of the quadruple aim framework whenever possible:

- Improving the patient experience of care (including quality and satisfaction),
- Improving the health of populations,
- Reducing the per capita cost of health care, and
- Provider satisfaction (professional wellness).

The examples included are evidence-based with measurable outcomes and meet the definitions of rehabilitation set out in the RCA's Definitions Framework for Community Based Levels of Care.

While current challenges of access to and availability of community-based rehabilitation are acknowledged, Parts 2 to 4 of this paper will provide recommendations on the provision of community-based rehabilitative care based on the evidence. Please note that this paper does not recommend one model of care over another, but presents options, which may be adapted to local contexts.

Part 1 was developed by an In-Home Clinical Subject Matter Expert Group, made up of a broad group of provincial stakeholders, and validated by the RCA Community Rehabilitation Advisory Group.

APPENDIX A: IN-HOME SUBJECT MATTER EXPERT GROUP

Committee Chair: Charissa Levy, Executive Director
Rehabilitative Care Alliance

RCA Project Managers: Rebecca Ho
Gabrielle Sadler

Name	Organization	Title	LHIN
Courtney Bean	VHA Home Healthcare	Director, Client Services	TC
Kayla Boland	Creative Therapy Associates	Occupational Therapist	NW
Jeanne Bonnell	Champlain LHIN	Acting Director of Home and Community Care	CH
Janet Brookes	Champlain LHIN	Manager of Rehab, Home and Community Care	CH
Cathy Comeau	Community Advantage Rehabilitation	Director of Quality	CE
Heather Condello	Complex Injury Rehab	VP of Operations	CE
Andrea de Jong	Heart and Stroke Foundation	Stroke Best Practices Project Lead	Provincial
Derek Debassige	Manitoulin Physio Centre	Clinic Director & Registered Physiotherapist	NE
Jacobi Elliott	University of Waterloo, School of Public Health and Health Systems	Research Scientist	WW
Anthony Grande	Focus Physiotherapy	Executive Director	MH
Theresa Grant	Champlain LHIN	Project Manager	CH
Shannon Mulholland	Ontario Physiotherapy Association	Home and Community Care Committee Member	Multiple
Emily Nalder	University of Toronto	Associate Professor	
Ashley Oliver	Focus Rehab	Registered Social Worker	Multiple
Karen Pontello	Partners In Rehab	Managing Partner	NW
Riva Sorin-Peters	Revive Speech Therapy	Speech-Language Pathologist	TC
Sarah Tam Lee	SE Health	Advanced Practice Leader, Rehab	Multiple
Maggie Traetto	West GTA Stroke Network	Regional Community and LTC Coordinator	CW
Colleen Worsley	Complex Injury Rehab	Manager of Community Engagement	CE

APPENDIX B: COMMUNITY-BASED REHABILITATION ADVISORY GROUP

Committee Chair: Charissa Levy, Executive Director
Rehabilitative Care Alliance

RCA Project Managers: Rebecca Ho
Gabrielle Sadler

Name	Organization	Title	LHIN
Puja Ahluwalia	Access to Rehabilitation - Project Coordinator	Realize	TC
Juvy Alix-Lloren	Clinical Resource Coordinator	Unity Health Toronto - Providence Healthcare	TC
Sarah Grace Bebenek	Policy Analyst	Ontario Physiotherapy Association	Multiple
Sandra Best	Nurse Case Manager RPN	Excel Care Accident Benefit Specialists	MH
Jeanne Bonnell	Acting Director of Home and Community Care	Champlain LHIN	CH
Loretta Bourke	Manager Rehabilitation	Middlesex Hospital Alliance	SW
Eileen Britt	Regional Stroke Rehab and Community Coordinator	Central South Regional Stroke Network	HNHB
Gwen Brown	Regional Community & LTC Coordinator	Stroke Network of Southeastern Ontario	SE
Emily Bruni	Physiotherapist	Sault Area Hospital	NE
Darlene Burgess	Clinic Manager	Charlton Physiotherapy/Life Clinic Medical and Wellness Group	HNHB
Sameer Chunara	Senior Physiotherapist, Clinical Director	St. George Physiotherapy Clinic	TC
Cathy Comeau	Director of Quality, O.T.	Community Advantage Rehabilitation	CE
Meaghan Cosgrove	Physiotherapist	Huron Perth Healthcare Alliance	SW
Jeane Davis Fyfe	Manager of Outpatient Rehabilitation and Specialty Clinics	Hotel Dieu Shaver Health and Rehabilitation Centre	HNHB
Andrea de Jong	Project Lead - Stroke Best Practices	Heart and Stroke Foundation	TC
Rebecca Fleck	Director, Regional Rehabilitation Program	Hamilton Health Sciences	HNHB
Esme French	Regional Stroke Rehabilitation Specialist	Thunder Bay Regional Health Sciences Centre	NW
Margaret Furman	Operations Manager	SE Health	Multiple
Paulette Gardiner Millar	Director of Operational Communication & Quality Improvement	PT Health	HNHB
Marie Graham	Divisional Director Therapy & Rehab	Bayshore Healthcare	Multiple
Anthony Grande	Executive Director	Focus Physiotherapy	MH
Jelena Guscic	Reg. Physiotherapist/Bus. owner	Sherway Physiotherapy	CW
Jennifer Harris	Regional Manager CVD Prevention & Rehabilitation Outreach Programs	University of Ottawa Heart Institute	CH

Committee Chair: Charissa Levy, Executive Director
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Name	Organization	Title	LHIN
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Shelley Hickson	Physiotherapist	Champlain LHIN	CH
Jamie Holmes	Manager - Outpatient Rehabilitation Clinics, OT. Reg. (Ont.)	Halton Healthcare	MH
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Andrew Kim	Physiotherapist	College of Physiotherapists of Ontario	TC
Renee Konidis	Clinical Coordinator	University Health Network	TC
Danielle Lawrene	Cardiovascular Rehabilitation Supervisor/Case Manager	University Health Network	TC
Janet Legge McMullan	Clinical Program Lead	Health Shared Services Ontario	Multiple
Jacquie Levy	Clinic Director, Clinical Physiotherapy Specialist Neurosciences	Action Potential Rehabilitation	CH
Brenda Liddle	Speech-Language Pathologist	Muskoka Algonquin Healthcare	NSM
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Mary Luccisano	Physiotherapist	Luccisano Physiotherapy	C
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Kristine McGinn	COO	Assurance Home Care	CH
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Aruna Mitra	Director Home and Community Care	Central West LHIN	CW
Angela Mitrovic	Physiotherapist	Trillium Health Partners-Credit Valley Hospital	MH
Scott Munro	Director of Outpatient Rehabilitative Services	St. Joseph's Care Group - Thunder Bay	NW

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Name	Organization	Title	LHIN
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Emmi Perkins	Director, Quality, Performance & Design	Waterloo Wellington LHIN	WW
Maria Pevialyn Salada	Registered Physiotherapist	Sherway Physiotherapy	MH
Shirley Price	Interim Director, Programs, Rehab & Ambulatory Care	West Park Healthcare Centre	TC
Shannon Reid	Physiotherapist + Interprofessional Clinical Education Lead	West Park Healthcare Centre	TC
Jennifer Roberts	Manager of Rehabilitation	Bayshore Healthcare	C
Amanda Ross	RN, Manager Inpatient Rehab & Dialysis	Bluewater Health	ESC
Adam Saporta	Manager of Central Booking	Sunnybrook Health Sciences Centre	TC
Wendy Sarsons	Physiotherapist / Practice Owner	Action Potential Rehabilitation	CH
Seema Shah	Speech Language Pathologist	Kickstart Therapy	MH
Catherine Singer	UHN Patient Partner	University Health Network	TC
Anna Marie Sneath	Manager, Ambulatory Services	Unity Health Toronto - Providence Healthcare	TC
Michelle Sophie	Manager	Durham Physiotherapy Clinic	CE
Mary Tasz	Director, Regional Child and Family and Regional Therapy Services	North East LHIN Home and Community Care	NE
Denise Taylor	Northwest Regional Rehab Care Program Manager	St. Joseph's Care Group - Thunder Bay	NW
Susan Teengs	Clinical Supervisor	Integrated Rehab Professionals	CE
Maggie Traetto	Community and Long Term Care Coordinator	West GTA Stroke Network	CW
Elizabeth Udler	Physiotherapist	West Park Healthcare Centre	TC
Susan Varughese	Clinical Specialist	Canadian Institute for Health Information	Multiple
Saagar Walia	Coordinator	St. Joseph's Health Care, London	SW
Jessie Wat	Physiotherapist	Towncentre Rehab Clinic / Credit Valley Hospital	CE
Emily Watson	Physiotherapist, Community Development Lead	The Burlington Family Health Team	HNHB
Sean Willis	Director of Therapy	Woodstock Hospital	SW
Kevin Willison	Adjunct Professor/Educator	Lakehead University/University of Toronto	NSM
Tiffany Wu	Patient Flow Coordinator	Unity Health Toronto - Providence Healthcare	TC

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